University of Alberta

Changing a dressing: The nurse's experience.

by

©

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Abstract

Wounds and wound care have been part of the human condition from earliest history. Wounds are characteristically painful, primarily at dressing change. The impetus for this project was the observation that nurses, who are the main care providers of chronic wounds, continue to ignore or minimize pain, despite the fact that pain has a negative impact on wound healing. In addition to the literature supporting the value of pain management, pain rating scales, analgesia and non-traumatizing dressings are readily available and yet not routinely accessed by practitioners during dressing changes.

This study evolved from the desire to better understand the meaning of providing wound care for nurses across the continuum of care. A hermeneutic phenomenological approach was used to develop an understanding of what changing a dressing means to nurses. Eighteen registered nurses with a minimum of one year's experience in providing wound care participated in this study, to reflect the reality of the work environment across the health care continuum of hospital, community and long-term care settings. Each nurse participated in tape-recorded, open-ended interviews which provided rich data for interpretation.

The voices of the nurses in this study provide perspectives on the wound itself, the world beyond the wound (time, environment and relationships) and the hands-on meaning of changing a dressing. This study may contribute to further understanding of nurses' work as it presents an intimate view of what nurses think and feel about what they do.

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Chapter One

"For all the happiness mankind can gain
Is not in pleasure, but in rest from pain"
-John Dryden 1631-1700.

As long as humans have experienced debilitating illness, immobility, incontinence, dehydration, and malnourishment, chronic wounds (also called bed-sores, decubitus ulcers or pressure ulcers) have existed. Aside from the physiological composition of the wound, the most common related feature is pain, which has been demonstrated to significantly decrease the healing potential of the wound bed. The literature provides a holistic approach to pain and trauma in chronic wound care. This supports assessment of the patient prior to dressing change, including the use of pain assessment tools, appropriate analgesia prior to dressing change and selection of non-traumatic dressings (Krasner, 1995; Rook, 1997). However, the majority of the available literature on the topic of chronic wounds continues to focus on the functional aspects of dressing changes (Cervo, Cruz, & Posillico, 2000; Sharp, Burr, Broadbent, Cummins, Casey & Merriman, 2000; Takahashi, Kiemele & Jones, 2004).

Historically, tending to wounded soldiers was one of the original roles of nurses. Wound care continues to be included in the education of nursing students as part of the basic skill repertoire. While students learn the theory of the integumentary system they are also exposed to wound care during their clinical rotations on medical and surgical units. Because chronic wounds require on-going intervention, nurses in all clinical settings across the continuum of care of hospital, home, or long term care facilities may be involved in changing dressings.

How a nurse uses touch, body language, and voice assists in establishing rapport with patients as well as enhancing effective assessment and treatment (Kacperek, 1997; Metcalf, 1998; Wurzell, 1981). These aspects are components of a therapeutic intervention repertoire that include both objective and subjective data. The ability of the nurse to provide patient-centred care that addresses the bio-psycho-social-spiritual nature of human beings incorporates the art and science of nursing (Scholtfeldt, 1988). While nursing has often been referred to as a caring profession (Henderson, 1964; McKenna, 1993), my observation of nurses providing wound care would indicate that this intervention, which offers the opportunity for meaningful interaction, is often relegated to a functional task to be completed as quickly as possible.

Purpose of the Study

The purpose of this research study was to explore and describe the nature of wound care management from the perspective of nurses who provide wound care across the continuum of care settings. In particular, the study aims to understand the elements, both extrinsic and intrinsic to nurses, which impact on their ability to provide care during dressing change. Phenomenology offers a way of exploring the "being-in-the-world" experience of the nurse, as it centres on his or her construction of the act of changing a dressing.

Wound care involves the use of skills that, on initial view, may appear to require little more than technical proficiency at cleansing, wound assessment, and dressing change. Although wound care is learned as part of every nursing student's education, the opportunity for actual practice is limited to brief clinical experiences. Personal experience and observation over seven years as an advanced nurse practitioner in wound management indicate to me that wound care involves much more than a functional task to be completed. The phenomenological approach enabled an exploration of what it is like for nurses to change a dressing. Employing a phenomenological research approach provided a framework that begins with the circumstances of the event (changing a dressing). The process of reduction and hermeneutic interpretation then enables a deeper perception of what this experience means in the context of everyday nursing.

> Phenomenology does not offer us the possibility of effective theory with which we can now explain and/or control the world, but rather it offers us the possibility of plausible insights that bring us in more direct contact with the world.
>
> (van Manen, 1997b, p. 9)

The study will inform nursing care and, hopefully, lead to improvements in nursing practice in this area.

Coming to the Question: The Journey

Phenomenology requires a 'reduction' which is a way of leading the mind back to a place of clear reflection that enables one to experience what Merleau-Ponty referred to as the "direct and primitive contact" of a phenomenon (Merleau-Ponty 2002, *vii*). The reduction involves peeling away of layers of conditioned, reality; to pare away all but the essential elements of the experience (van Manen, 1997b). As a researcher, it is important to recognize and address the value-laden personal biases which impact upon one's view of the phenomenon under discussion (Thompson, 1985).

Thus my own approach to the topic of wound care starts with a question of the origin of my interest in the topic, particularly in the relational aspects of the experience of changing a dressing. On reflection, it seems clear that my interest stems from some deeper place than the observation of nurses providing wound care.

The child. My first experience was of my own body and this wound still remains as a faint, raised pink ribbon across skin, like remnants of sidewalk art, blurred with time and age. The aging of skin changes the appearance of the healed wound, but the scar still has the clear, deliberate lines of the surgeon's blade, the raised points, reminders of the black thread, knotted and neat. This is the memory of a surgical incision made when I was six as treatment for an acutely inflamed appendix.

The eight stitches (the marks still remain and can be counted) had to be removed. I was terrified at the thought of pain, the fear of the unknown experience, and loss of what little control I had in the world of the hospital. The incision line, about five inches long, extended along my lower abdomen on the right side, a neat, straight cut, with long black stitches on either side. It was the doctor's eyes I remember. He held my gaze as he talked to me about removing the stitches. He spoke in a calm, quiet voice; he made a joke. His touch was firm and gentle. He stopped between removing each stitch to ask me how I was doing. There was no pain, no fear, as he gently removed the stitches, carefully, one at a time.

The caregiver. I was the caregiver next. My sister and my mother, in quick succession, had abdominal surgeries. Each came home from the hospital, with drains still intact and still draining. They could not see the incisions themselves, so the dressings required other hands, other eyes. I was old enough at fourteen and sixteen to provide the care. I was their eyes; I could tell them what I was seeing. I was their hands; I could touch them the way they would have done. And because it was not my body, I could look with some objectivity at the appearance of those draining wounds.

As I cleaned and re-dressed their wounds, I felt connected to my sister and my mother. I was contributing to their healing: actively, physically doing something. Overcoming the helplessness of not being able to cure the cause of their surgeries, I felt useful and connected to them in an intimate way that would not have been possible otherwise.

The nurse. My experiences with wounds were first in observing others conduct dressing changes. I was struck by the difference in approaches, and the results achieved by different nurses. It seemed to me that some nurses dealt with the needs of the patient in ways that minimized the pain of the dressing change, while other nurses hurried through, pulling off the dressing quickly, often producing painful responses from the patient. As I became more involved in wound care, I began to pay more attention to the pain and trauma associated with dressing changes. Thus, I became concerned about dressing changes that were carried out in a manner that appeared to not reflect patient-centred care.

What is it like to change a dressing? For me, changing a dressing is an expression of who I am as a nurse. It is a way for me to integrate the skills of assessment, treatment and relating to the patient and his or her family. As Gadow (1995) describes, this intersubjective response is an expression of the merged perceptions of both nurse and patient. For me, it is one of the essential elements for the foundation of the nurse- patient relationship.

I cannot truthfully recall the first wound I dressed as a nurse. However, when I change dressings, I bring to the task the memories of the pediatric surgeon, my sister, and my mother, despite the fact that I am mostly unconscious of their presence in my hands, my eyes, or my voice.

Changing. From a physical perspective, changing a dressing means I too must change. I put on examination gloves and often a gown as well when contact precautions are necessary. I let the patient know I am there, either by knocking on the door before entering the room, or speaking before opening the curtain around the bed. My pace is rarely fast. I come to the bedside as if entering an unknown pool. The wound is my focus, but I am still aware of the sudden intimacy with the patient's body that occurs as I uncover the naked flesh to reveal the wound. As Hagar Shipley, the aged protagonist of "The Stone Angel" (Laurence, 1964) experiences, there is no time to acclimatize gradually to the thought of a stranger seeing one's body. "Then swiftly, the tables turn. [The doctor] bids me disrobe, holds out the stiff white gown. Then he walks out of the room. Why bother granting this vestige of privacy, when all's to be known and looked at, poked and prodded, in only a moment?" (Laurence, 1964, p. 91).

The focus of my attention, while on the reality of the wound, also rests in branches where body image, emotion and fear perch. The suffering is so much more than the physical pain of the wound. Like Hagar Shipley, the physical condition of my patients reinforces the lack of control they have over their bodies, unable to perform even the simple act of getting up out of a chair: "The arthritis knots inside my legs as though I had pieces of binder-twine instead of muscles and veins. My ankles and feet (thick as stumps they are now, and just about as easily moved—one has to uproot them) stumble a very little over the edge of my bedroom rug" (Laurence, 1964, p. 30-31).

Mrs. M, whose legs are swollen and dry as the skin of elephants, weeps at the pain of touch. But she also weeps at her frustration that these "stumps" as she calls them, are so resistant to healing, preventing her from living life that doesn't focus on how she can lift her legs to move from the bed to the wheelchair. "It's not a life" she tells me, in tears.

Her legs are swollen, taut with fluid. There is a heaviness, a lack of definition in the shape of the leg as the characteristic curves of ankle and calf disappear. My fingers, pressing skin the colour of bread dough, leave an indent long after I remove the pressure. The dry skin flakes off in scales as I run my hand along the side of her leg. Her legs are cool to the touch; her feet and toes feel refrigerated through my gloved hands. "Those feet are always cold", she says. I am struck by the surprise in her voice, as if her feet had a life of their own. Gadow describes this characteristic of the illness experience when the body becomes the focus of attention as creating "an object of consciousness" (Gadow, 1994, p. 296). Illness seems to separate the body and transform it from a state of wholeness to a collection of parts.

A wound is evidence of this separation, as it can be perceived as a physical manifestation of disintegration and loss of integrity. The wound contributes to the disengagement from the body because it is often located where the patient cannot physically see it. Thus the wound becomes even more extant from the body and may contribute to the disconnection patients experience when hospitalized (Wilde, 2003). Mrs. M, for example, feels she is unable to do anything to change the temperature of her feet. They have a life of their own "as if they belong to someone else", she says.

Photo: Right leg cellulitis

Beneath the surface. Lily is a ninety year old woman. She has lived alone at home and has been hospitalized a number of times before, but now both she and her family are realizing that she cannot manage on her own any more. However, this doesn't prevent her from arguing adamantly that she doesn't need our help. When admitted to the hospital, she was dehydrated, malnourished and confused. Both legs were inflamed, edematous and excruciatingly painful. The wounds were draining large amounts of malodorous, purulent yellow-green exudate. She was treated with systemic and topical antibiotics, which seemed to work well to improve the condition of her wounds. As well, narcotics were provided to help ease the pain.

Because she has Methycillin-Resistant Staph Aureus (MRSA), she is in a private room. On this day, I have come to re-assess the progress of our treatment plan. Lily is well-known to me from previous admissions. She is a tall woman, with a face that reminds me of Marlene Dietrich, the blonde singer from the Second World War. Despite the fact that she is ninety, Lily's face has almost no wrinkles. Her skin, other than the lower legs, is beautiful, supple and warm. Her fine white hair had been brushed by her daughter that morning, and it flows onto the pillow.

When I entered her room, she was lying still, with her eyes closed, hands clasped over the blankets on her chest. She looked uncannily like a corpse, laid out for a wake. But her eyes opened, she sighed deeply, and then saw me. "Oh no" she moaned, "you're here to take those goddam dressings off. Everything hurts! Can't you just go away and leave me alone?" The dressing change had been such a terrible experience for her in the past, because of the pain of the infection, and the length of time it had taken to initiate effective analgesia. Patients in pain may experience a sense of separation from their bodies (Thomas, 2000) or the pain can become overwhelmingly powerful as it infiltrates not only the physical but the cognitive, spiritual and social aspects of the body (Clark, 1999). Unlike Mrs. M, Lily had become totally immersed in the pain from her infected leg.

I checked with her nurse; she had just received 2mg of morphine prior to my arrival. I hoped it would begin to work soon. The room was dimly lit other than the one pot-light in the ceiling to illuminate the lower half of the bed. I have given Lily a towel to protect her eyes from the glare of the light. The morphine is taking effect. Her hands are no longer clenched into fists, but relaxed. Her breathing is regular and when I ask her how she is feeling, she breathes out a sigh, "Fine. I'm fine now…" I tell her that the medication is helping her relax so I can open the dressings and look at how the wounds are healing. " Okaaay.", she drawls " go ahead…"

I am prepared for the stench of the infection as I begin to cut away the wrapped bandage. The sweetish smell reminds me of chrysanthemums just past their prime, wilting and brown around the edges. I chew mint gum and breathe through my mouth to help mask the odour. Patients are often embarrassed by the smell of their wounds. In Hemingway's short story, " The Snows of Kilimanjaro" (1936), the main character, Harry, is a writer now dying from gangrene that developed as a result of ignoring a thorn scratch on his leg. The story opens with Harry apologizing for the smell of the wound. When his wife tells him she barely notices, he angrily replies, "Why don't you use your nose? I'm rotted half way up my thigh now" (1995, p. 18).

Photo: Palliative patient

I approach the cover dressing with some trepidation; one never knows exactly what its removal will reveal. The gauze wrap that I carefully prepare to cut away has hidden the deteriorating flesh I am expecting. The gauze pads fall back and now I can see the collection of wounds that cover the lower leg. I breathe out. My first thought is, "good, these wounds are healing". I take this in as a fresh breath (the odour has gone). Touching the skin, I feel dried scabs that are ready to be removed. Lily doesn't flinch when I gently lift the edge of a scab and pull. It comes off in my gloved fingers. Underneath is pink, shiny epithelial tissue.

Changing within, changing without. For the next hour, I carefully remove the dried skin and blackened scabs with tweezers. It takes that long because I stop frequently, rub Lily's legs with cream, talk to her. She tells me snatches of stories of her life. As we talk about the progress of her wounds, she says, "I 'm so glad it's healing. I should be able to dance soon, don't you think?" We both laugh.

We are alone in the room and time seems to have gone elsewhere. The relationship between us has grown to include more than the wound. Like Hana, the nurse in Ondaatje's "The English Patient" (1992), the intimacy of caring for the wounded patient has provided us with the ability to transcend the demands of the external world. " He whispers again, dragging the listening heart of the young nurse beside him to wherever his mind is, into that well of memory he kept plunging into during those months before he died" (1992, p. 4)

As I cleanse the wounds I can feel how the skin and the underlying tissue are responding to my touch. The warmth of Lily's skin points to the increased circulation, not infection. Her level of pain has decreased too, since she has neither complained nor shied away from my touch. I choose a dressing that will be comfortable and require less frequent changes. Now my job is to put things in order. It is important to me that her world reflects order, not the chaos of wounded flesh.

The dressing change has been a way to engage with the patient beyond the physical task. An opportunity to change the relationship between the patient and the wound can be created through attention to mind-body harmony (Wilde, 2003). The experience with Lily helped me realize that the exploration of the patient's approach to life while we talked about the genesis and progress of her wounds, assisted her re-connect with her body and gave me an appreciation for this woman and her life story.

I recognize that my position at the bedside is unique. The focus of my clinical work is primarily wound care, and in general, I have control of the amount of time I spend with each patient. However, within the experience I share with other nurses who change dressings are stories and voices that will bring some clarity and understanding to the question, 'What is it like to change a dressing?' It is in the reading and sharing of these stories and voices that nurses will find resonance with their own practice and heighten their awareness as they provide wound care.

The Therapeutic Relationship

Hildegard Peplau was a nursing theorist whose work reflects her belief that the therapeutic relationship is central to nursing. "It is educative and therapeutic when nurse and patient can come to know and respect each other as persons who are alike, and yet different, as persons who share in the solution of problems" (Peplau, 1952, p. 9). While Peplau's work was directed towards the domain of psychiatric nursing, the value of the therapeutic nurse-client relationship may be applied to any practice area.

Being able to develop an understanding of the patient's perspective provides a way to effectively assess his/her needs. Gastmans (1998) points out that in order to do this, the caregiver must become involved with and open to the experience of the patient. This view is difficult to enact within the pressured, high-acuity world of health care environments that are driven by cost containment and the bottom line. Nonetheless, the essential aspects of relationship-building would seem to be necessary if nurses are to engage in anything more than functional task completion.

For example, in the past, wound care was primarily focussed on the wound itself, without taking into account the holistic needs or wishes of the patient/family. During the past ten years, there has been a shift in thinking which incorporates not only the goals of patient/family which include healing but also comfort measures (e.g., in the case of a dying patient). As well, both nurses and patients are more likely to be familiar with complementary therapies, such as therapeutic touch or guided imagery, which support engagement within the nurse-patient relationship.

Guidelines and Standards

Despite the ready availability of dressings to decrease pain/trauma, the fast-acting, short-lived opioids, the pain assessment tools, and the availability of Best Practice Guidelines, many nurses persist in doing dressings in a less than ideal way. Although the current literature provides little direct research evidence on this topic, research findings about nurses' attitudes and behaviours in pain assessment and management among medical, surgical and pediatric populations consistently demonstrate a lack of appropriate pain rating and/or relief (Field 1996; Schafheutle, Cantrill & Noyce, 2001; Seers 1987).

In the United States, pain has been identified by the Joint Commission on Accreditation in Healthcare Organizations (JCAHO, 2000) as the fifth vital sign. This action has helped ensure that pain assessment is mandated as part of standard care assessment protocols, along with respiration, heart rate, pulse and blood pressure. The Canadian Council on Health Services Accreditation (CCHSA) has recently incorporated the Canadian Pain Society's position statement ("Patient Pain Manifesto") in the Achieving Improved Measurement (AIM) standards by insuring that processes to assess and manage pain are in place. These standards, which have been revised for implementation in 2005 (CCHSA, 2003), will hopefully have an impact on how nurses assess and manage painful procedures such as dressing changes.

In addition, the inclusion of pain as the fifth vital sign has created a need for nurses to become more attentive to the assessment and management of pain. These activities also require the participation of the patient/family in both assessment and intervention for pain management. The increased public awareness regarding the mandated requirements for pain assessment and treatment have created an opportunity for professional awareness as well. Thus it would seem that the understanding of pain in wound care would entail an understanding of the impact of therapeutic relationship.

Complexity of the Therapeutic Relationship

As I began to write about the meaning of therapeutic relationships in the provision of wound care, I kept coming back to the image of Picasso's "Blind Guitarist".

Blind Guitarist, Picasso, 1903 (Art Institute of Chigaco)

When I am asked to see an elderly patient with a pressure ulcer, I often have this picture in my mind's eye. I see this painting with its dark and somber blues, browns and black, the old man hollow-cheeked, awkwardly bent over, with an angular thin frame, dressed in rags and bare feet, lost in the chords of his guitar.

The look on his face is one of sadness or is it that he is listening so carefully to the music he plays? He is so completely absorbed in the instrument, in holding it, listening to it. The old man is painted like a self-contained object, but one that is perfectly at home in his background. However, there is a sense of unease, discomfort—from his position, the condition of his clothing, his gaunt appearance.

Picasso has given the painting a complexity that, despite its balanced esthetic structure, has a dissonance to it. Who is this old man? Where is he situated in his world? It is such an image that holds strength and fragility; pride and despair; beauty and pathos. The story of this blind guitarist is for the viewer to tell. I wonder if he is a beggar on the street: I have seen men like him, on the streets of London, Edmonton, Vancouver, Toronto—strumming the same chord, over and over again, with a cup in front of the crossed legs.

On the street, I have walked by this man, barely acknowledging his presence. And yet, despite the distance I place between us when I walk by him on the sidewalk, when he enters my world, needing my care, I enter his world, wanting to know it.

Thinking about this powerful visual image and its implied effect on my nursing practice, I cannot help but recognize the ambiguity of my response. What I desire is the ability to be consistent with how I think about this individual and how I respond to him, which Jardine (1998) describes as "…a sense of objectivity that is pronounceable with a gusto and confidence and clarity of the 'I am'. We long to be *right*" [italics in the original] (p. 17).

The beggar on the street is in his world, where the nurse has no role; however once he enters the hospital, the beggar/patient is in a position where personal identity may be lost. The institution becomes 'right' with the mandate of rules about personal effects, behaviours, visitors. The nurse then becomes the gatekeeper who can choose to respond within the institutional framework or with a willingness to understand the story and the identity of the person/patient. Engaging in care requires contact, which in turn requires a relationship. The nurse, poised in the doorway, is potentially caught in the ambiguity and discomfort of the situation. His or her response is balanced on this fulcrum, with the institutional culture of care on one side and the internalized personal culture on the other. One is thus presented with the nature of relationship that is not clean and neat, despite the desire for it to be so, but rather an example of what John Raulston Saul (2001) describes as the complexities of life which confound the search for equilibrium.

The image of the beggar on the street transposed to the patient in the hospital bed is uncomfortable. But more uncomfortable is my own reaction to the same man in different environments. Entering this patient's room, I am confronted with the personal/professional dichotomy which Gadow (1980) recognizes as a key to being able to effectively advocate for the patient: " For the patient's emotional complexity to be understood and supported, the emotional dimension of the nurse's own being cannot be excluded, but must be consciously and directly engaged " (Gadow, p. 92).

Beginning to understand the dissonance in behaviour, of ignoring the beggar on the street yet providing him with compassionate and respectful nursing care when he is the patient, is part of a process of becoming aware of values and actions that impact on care.

Autonomy and Advocacy

Society, culture and legislation, particularly in the Western world, have supported the value of the individual's right to choose how to live his or her life. The United Nations Universal Declaration of Human Rights (1948) affirmed support for the rights of individuals to choose freely how to live their lives (moral or otherwise). In Canada, this document formed the basis of the Canadian Human Rights Act (1977) which reflects this essential belief in personal self-direction.

This concept of autonomy has been entrenched within health care. For over thirty years, North American medical ethics have included the principles of autonomy, beneficence, nonmalefiecence and justice (Beauchamp & Childress, 1970/2001). In their comparative review of national medical systems, Mechanic and Rochefort (1996) identify the current interest in patient participation, choice and voice in the organization of health services. In 1999, for example, over 60 million Americans searched the internet for health related topics (Drake, 1999). As patients and their families become better informed regarding treatment options, there is an increase in demand for participation as health care consumers (Charles, Gaffney & Whelan, 1999).

However, participation can be affected by attributes such as age, gender, class, culture, or religion. For example, society, religion and cultural predilection place children in a dependent role where decision-making is the responsibility and in many cases, the right, of the parent/guardian. This occurs despite the fact that research has shown that children over the age of eleven are able to reason and generalize beyond personal experience, thus demonstrating the capacity for an understanding of the benefits and harms of treatment (Bibace & Walsh, 1980).

Meaning of autonomy in health care. In the health care setting, autonomy is the right of the patient to make informed choices regarding care, with the expectation that health care professionals will ensure information is made available, enabling patients to enact decisions that are truly self-directed. On the surface, this institutional endorsement appears to provide a method of entrenching patient rights to decision-making and personal control (Sherwin, 1998). However patients are, by the very fact of their state of illness, potentially "vulnerable to manipulation and even to outright coercion by those who provide them with needed health service" (p.20). For this reason, much attention has been paid to the right to self-determination and decision-making for children, mentally challenged adults and the elderly (Doig & Burgess, 2000; Dunn, Lindamer, Palmer, Schneiderman, & Jeste, 2001; Wong, Clare, Holland, Watson, & Gunn, 2000).

Forces at work. Respect for patient autonomy is thus difficult because it is fraught with complexity. From a feminist perspective, autonomy requires the interdependence of relationship (Sherwin, 1998; Bergum, 2003) to overcome the egocentric individuality promoted by traditional views of autonomy (MacKenzie & Stoljar, 2000; MacDonald, 2002; Goldberg, 2003). The dynamics of overt and covert power processes within patient/family and health care professionals effect the enactment of autonomy (Pyke, 1999). While healthcare professionals are considered a privileged class who are expected to demonstrate leadership (Gastaldo & Holmes, 1999), the values of patients may be not only different from but in conflict with the values of the healthcare providers. This only serves to entrench the inability of healthcare professionals to comprehend the perspective of the 'minority' patient (Leininger, 1997).

Balance of power. Diminishing patient power has the effect of maintaining the status quo of the medical model, ensuring the survival of the paternalistic control of decision-making (Gastaldo & Holmes, 1999). Thus, the balance of power as knowledge may be heavily weighted on the side of the care providers, leaving the patient disadvantaged from the start (Pyke, 1999). The notion of informed consent is based on assumptions that patients have the intellectual and communicative capacity, are accustomed to making choices about their lives, and have the resources available to them that allow for options to be explored and selected (Sherwin, 1998).

Research indicates that decision making by patients and family members is often based on emotional involvement and value commitments "… which determine the sources of information from which people draw, how they interpret what they see and what they believe they ought to infer from what they believe they have learned about the situation at hand" (Roberto, 1999, p. 168). In fact, the patient's life is often very different from that of the health care provider. Illness, aging, pain, cognitive and socio-economic deficits are some of the limitations facing patients who are not usually in the sick role by choice, and often have not had the ability to make many significant choices in their lives.

Approached while in a hospital bed (hearing aid, glasses and dentures in the drawer of the bedside table) by a highly educated and articulate health care professional who has a treatment plan in mind, it would take energy and attentiveness to be able to lucidly provide the patient's perspective on the proposed plan, especially one that was in disagreement with the health care professional.

Professional autonomy. In addition, it is important to recognize that the control exerted by healthcare providers over patients is also affected by the ability of the healthcare providers themselves to function in an autonomous way. Historically, physicians have had the authority (both officially and legally) to direct nursing practice, although the past twenty years have seen major changes in the ability of the nursing profession to self-direct (Laschinger, 1996; Bradshaw, 1995). Advanced educational preparation with more focus on critical thinking, the use of evidence-based knowledge in clinical practice, the expansion of nurse practitioner roles and the acceptance of interdisciplinary teams have all contributed to the potential for nurses to function with increasing levels of professional autonomy (Roberts & Vasquez, 2004).

Despite these changes, many healthcare settings have remained comfortably supportive of the status quo. In many cases, nurses themselves have been reluctant to lobby for professional autonomy (Laschinger & Havens, 1996). Multiple factors can be implicated in this state of oppression, including tradition, socialization, and media image (Erickson, Hamilton, Jones, & Ditomassi, 2003; Roberts, 2000). It makes sense that when nurses perceive themselves as powerless to exert control and judgment within the practice setting, they may be less likely to support autonomous decision-making on the part of patients.

Advocacy: walking the walk. While autonomy is the right of self-determination, advocacy is the actualization of autonomy. The origin of the word, from the Latin *advocare,* is the root of the French word, *avocat,* or lawyer (Etymoline, 2004). By extension, the meaning of advocacy is then to support the beliefs or views of another and indeed follows the ethical model of beneficence (to do good) and nonmaleficence (to do no harm). Even with the moral tradition of beneficence, health care professionals may still be under the assumption that since they are the ones with the specialized education and expertise they are in fact better equipped to determine what would be best for the patient rather than the patient him or herself (Sherwin, 1998). This paternalistic view of advocacy in fact compromises the patient's autonomy (Haggerty, 1985).

Impact of power and privilege. For example, the man who requires a below-the-knee amputation to save his life from the threat of gangrene-related sepsis may refuse this option because he feels losing a limb would be more devastating to him than the possibility of death. Without clearly understanding this individual's reasons for refusal of surgery, the health care provider may be inclined to exert pressure to change the patient's mind, for example, approach family members or question his competence to make the decision. This view of advocacy does little to support the patient's right to information and service. Gadow (1980) describes this issue as critical in determining a perspective that is supportive of the patient's choice. Authentic advocacy runs the risk of being hampered when the intent (obtaining what is believed to be good for the patient) takes precedence over the actual wishes of the patient.

Information to decide. Consumer advocacy, which developed in the late 1940s in Canada, with the Consumers' Association of Canada (2004), supported the public's right to information, services and participation in decision-making. However, the role of consumer advocate in healthcare is to provide information to the patient rather than providing an opportunity to discuss other points of view (such as that of the health care provider). For example, the Code of Ethics for

Registered Nurses (Canadian Nurses Association, 2002) highlights the central role of the patient in active, informed decision-making and the role of the nurse to provide information and relevant services that enable the patient to make an informed decision. While this approach provides some aspects of advocacy (provision of information and services), the expectation is for the patient to assume all responsibility for decision-making.

Existential advocacy. A more balanced perspective may be that described by Gadow (1980) whose view of existential advocacy provides a relational perspective of providing nursing care. According to Gadow, the relationship between patient and nurse should be one that values both individuals and is based upon trust, respect and equality. Honest disclosure of values is essential in order to ensure not only true advocacy but also true decision-making (Falk Rafael, 1995).

Thus, autonomy and advocacy may be described as two sides of the same coin. However, there is a tension inherent in the balance of this coin, as the healthcare provider struggles to let go of the power of knowledge to enable the patient to make choices and decisions that truly reflect the individual's self-appraisal of the situation.

> I have become more aware of how fear is at the heart of prejudice and exclusion. We are all frightened of those who are different, those who challenge our authority, our certitudes and our value system. We are all so frightened of losing what is important for us, the things that give us life, security and status in

> society. We are frightened of change and, I suspect, we are even more frightened of our own hearts.
>
> (Vanier, 1998, p. 73)

This quote from Jean Vanier reflects the apprehension for both parties. Autonomy and advocacy are essential components in the provision of health care for both patient and care provider. The issues of power, control, knowledge, choice and decision-making are woven throughout interactions between patient and family and care providers. Articulation of the nature of these issues is a step towards overcoming the push-pull of this essential component of nursing.

Engaged care. As care providers and patients grapple with the dissonance between expectation and reality of the meaning of autonomy and advocacy, it is important for nurses and other care providers to understand the perspective of the patient. While this view assumes that there is an inherent connection between nurse and patient, the key is not whether there is a relationship between the caregiver and patient, but rather in how that engagement occurs.

The notion of engaged care described by Shultz and Carnavale (1996) includes a deep exploration and understanding of both the patient's experience and the nurse's own response to it. Engagement refers to the active process of "thoughtful mediation between universals and particulars in clinical encounters" (p.195). It is the nurse who assesses, monitors, adjusts, and deals with the moment-by-moment needs of the patient. How this relationship unfolds is, by and large, up to the nurse as he/she steps through the door to interact with the patient.

Clinical phronesis. Nursing is inherently about relationships. As Gastmans (1998) points out, even during the assessment phase of clinical care, the context and values of both the nurse and patient are essential. The data nurses collect regarding the patient's overall condition require an approach that is open to and involved with the experience of the patient at that particular point in time, and in terms of the patient's world. Thus the way in which the relationship is enacted appears to be dependent on how the nurse chooses to engage with the patient. Shultz and Carnevale (1996) describe this relationship as clinical *phronesis*, which involves amalgamating what is known about the individual patient and developing decisions based on the combination of what is clinically and ethically best for the patient. The process can only occur if the patient/family is involved in an on-going open dialogue with the health care providers.

Clinical phronesis, as a framework of care, has the potential to develop engaged practice so nurses are able to enter into meaningful, productive relationships with patients. In particular, care of the patient with a chronic wound can be enhanced because the awareness engendered by clinical phronesis ensures that attention will be paid to the individual patient's treatment issues, such as managing pain, trauma and potential for wound healing.

However, clinical phonesis is not a type of knowledge that can be didactically taught. Rather it is a process, requiring the nurse to be attentive, open, and accepting of an approach to clinical decision-making that is fully engaged. (Schultz & Carnevale, 1996). One of the first steps in this process is the recognition of "fellow-feeling", a term described by Max Scheler (1970) and referred to by

Schultz and Carnevale (1996) and also by Gadow (1980). Fellow-feeling is the shared experience of emotion between caregiver and patient in a way that transcends the self. It is the active involvement of patient and caregiver in the interpretation of the experience (e.g., the chronic wound) that opens a process of full engagement. While the power of fellow-feeling creates the emotional responsiveness of caregiver for patient, clinical phronesis shifts the caregiver's actions and thinking into a direction that is uniquely relevant to this particular patient (Schultz & Carnevale, 1996). In addition, the responsiveness engendered is not only towards the significance of the patient's experience but equally important, recognizes that the feelings of the caregiver in relation to this experience also have relevance.

Barriers to engagement. Care providers are often disengaged from the opportunity to relate to patients by the functional, efficiency-driven business units that provide the operating envelopes for the North-American health care system. For example, decision-making around wound care has been traditionally focussed on the dressing change, primarily the frequency of dressing change, since the standard use of wet-to-dry dressings has been part of the wound care repertoire for centuries. In addition, dressing changes along with other nursing interventions such as assessment of vital signs, have historically required physicians' orders, relegating the nurse to the handmaiden role of carrying out what the physician deems necessary. Despite the fact that wound care management is within the standards of practice for registered nurses according to their regulatory colleges (e.g., College of

Nurses of Ontario), many nurses and physicians are still under the impression that a physician's order is required prior to dressing a chronic wound.

Thus, wound care has traditionally been relegated to the housework component of patient care, along with other activities such as toileting and feeding. The task itself runs the risk of becoming identified as more important than its actual effect when it is embedded in a documented, institutional structure. According to Doering (1992), if the main concern is the task itself, the focus of attention may narrow to the details of how the task is performed without consideration of how this task is relevant to the overall care of the patient. As well, these fundamentals of patient care, which are routinized, repetitive, task oriented activities appear to offer little opportunity for the caregiver to pay attention to the situation of the moment or be assured that the task at hand is truly in the best interest of the patient (Sherwin, 1998).

In addition, clinical activity which is perceived to be essentially functional in nature such as wound care, may undermine the potential of the care provider to enter into a relationship with the patient because the activity is driven by the external, operational values such as cost-effectiveness and resource efficiencies. Because of the expectation of technical production, the focus is on performance of the task at hand, rather than on any sort of meaningful interaction with the patient.

While meaningful interaction may be perceived as a potential risk and flies in the face of the accepted view of professional objectivity, engagement on this level acknowledges and supports the essential, relational experience of caring for patients. It is the action that demonstrates value for the individual experiencing the care, as well as recognizing the essential human-ness of the care provider. This reconceptualization of the relationship between patient and nurse encourages truthfulness because it removes the barriers of power and oppression that have contributed to the entrenchment of functional, disconnected care.

Conclusion

In conclusion, the focus of this chapter has been to offer a discussion of how nurses and patients with chronic wounds are often in a world of conflict. The goals of autonomy, to enable to individual to make decisions that are best for him/her are often blocked by the disconnect that occurs in an environment where patients are marginalized and nurses are disempowered. The advocacy role of the nurse, to support best possible care for the patient, may be hampered by the nurses' own feelings of disengagement. Clinical phronesis offers an approach that may provide a way of improving nursing care. The gaps identified in research and in practice point to the need for an in depth exploration of the meaning of wound care practice (i.e., the act of changing a dressing) in order to better understand how nurses value the autonomy and advocacy roles, and how they view their own practice.

Chapter Two: Review of the Literature:

Situating the Study.

"In almost all diseases, the function of the skin is, more or less, disordered; and many most important diseases nature relieves herself almost entirely by the skin"

Florence Nightingale, (1859). Notes on Nursing, p. 52

The impact of a wound is complex. It affects not only the physiological structures of the skin, underlying tissue and bone, but impacts on quality of life. A wound is often an external indicator of subtle but significant changes within the body that can lead to loss of a limb or even death. This chapter contains the elements that reflect the complexity of the wound, including the history of wound care, the etiology of wounds, the relevance of pain and its effect on wound healing. These aspects provide a fundamental introduction to situate the meaning of wounds and wound care for the purposes of this study.

History of Wounds and Wound Care

Wounds have always been part of the human condition and have been documented throughout history with numerous texts from Egyptian, Roman, and Greek times (Haeger, 2000). In fact, a clay tablet from Sumeria (circa 2100 B.C.) lists treatment for wounds, including dried wine dregs, juniper and prunes (Majno, 1991, p. 46).

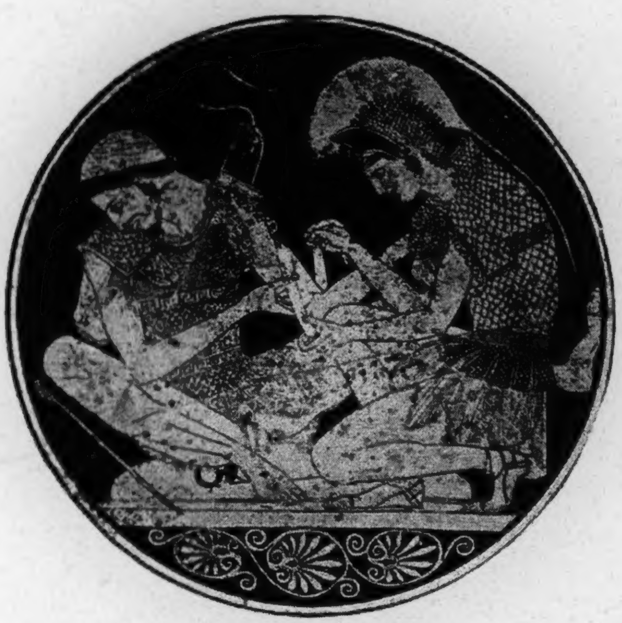
A variety of treatments throughout history have been used to heal wounds. For example, spider-webs were thought to control bleeding and were even referred to in Shakespeare's "A Midsummer Night's Dream (Act III/I): "I shall desire you of more acquaintance, Good Master Cobweb: If I cut my finger I shall make bold with you".

Ondaatje, in *The English Patient* (1992) describes the traditional methods used by nomads in the deserts of Africa:

> He crouched beside the burned man. He made a skin cup with the soles of his feet and leaned back to pluck, without even looking, certain bottles. With the uncorking of each tiny bottle the perfumes fell out. There was an odour of the sea. The smell of rust. Indigo. Ink. River-mud arrow-wood formaldehyde paraffin ether. The tide of airs chaotic…He began to rub green-black paste onto the rib cage. It was ground peacock bone, bartered for in a medina to the west or the south—the most potent healer of skin.
>
> *Ondaatje, The English Patient, p. 10*

Origins. The origin of the word, "wound" comes from Old German, ("*wunde*"), but its earlier root comes from the goth, "*winnan",* meaning "to suffer" (Hunter & Morris, 1899, p. 5224). A present-day definition of wound is: "any break in the tissue, skin or organ that is present through force (violence), accident or surgical incision" or "any injury or slight to the feelings or reputation" (Oxford dictionary, 1995, p. 1362). However, the physical wound with which nurses are most familiar is that which is caused by trauma to underlying tissue, creating non-viable tissue resulting in a pressure ulcer or pressure sore. Interestingly, *trauma* comes from the Greek "wound", the root of which is *tere*, meaning "to rub, turn"

(Etymonline, 2005). Rubbing of the skin is one of the causative factors of pressure sores.



Spartan warriors binding wounds 420-410 BC, Hellenic Ministry of Culture, Athens.

Care of the wound was one of the earliest roles for nurses, since throughout history, soldiers and civilians have been affected by the violence of war (Maher, 1999; Majno, 1991). In fact, the word *dressing,* as in "dressing the wound" or "wound dressing", has its origin in the military terminology of alignment of columns of troops, from the Old French, "*dresser*", meaning "put right, put straight", from the Latin, *directus*, meaning "direct, straight" (Hunter & Morris, 1899, p. 1751). The majority of the research literature that relates to wound care is focussed on assessment of the wound and treatment options. The appearance of the wound, its size, colour, exudate and odour are crucial observations to establish baseline and subsequent evaluation of progress.

Other topics, including etiology, the impact of pain, pressure, poor nutrition, moisture and friction and shear are also evident in the literature and readily available in web-based format. Attention is paid to determining appropriate dressing choices, pressure off-loading devices and other treatment options such as electrical stimulation. Best practice guidelines, such as those published by the Registered Nurses Association of Ontario (RNAO), provide evidence/best practice approaches to prevention and treatment of chronic wounds.

While all of this available literature offers indispensable information, knowledge and practical tools to give good care, research literature on the topic of the nurse's experience of dealing with wounds and wound care is scarce. In general, the focus of experiential research has been on the patient/family's response to a health issue or life experience (eg., diagnosis of cancer, birth, living with a chronic illness). Nurses themselves have been reluctant to explore the meaning of these 'mundane' aspects of care, despite the opportunity to develop an understanding of how these experiences, often repetitive and basic, impact on the nurses.

Laurene, acute care:

" It means that you're [the nurse] doing the care. You're at the bedside and you're getting your hands dirty. It's the use of your hands, I think, as being right there, you know, at the bedside. Like the worker bee".

As Lawler points out, "What literature there is on 'basic nursing' (physical body care) is almost exclusively recipe-type procedural material which emphasizes how to do certain tasks" (1991, p. 38). Certainly, the approach to wound care has focused on the technical nature of the problem, which can be addressed through an understanding of physiology and current treatments and procedures.

Pain Management in the Treatment of Chronic Wounds

Over the past decade there has been an increased interest in addressing the issue of pain associated with chronic wounds. Since the negative impact of pain on wound healing has been well-documented (Krasner, 1995; Reddy, Kohr, Queen, Keast & Sibbald, 2003) effort has been made to encourage the use of appropriate guidelines, assessment tools, analgesic medications and technologically advanced 'non-traumatic' dressings. However, achieving adequate pain control in wound care continues to present a challenge for health care practitioners, patients and their families (Eager 2002; Krasner, 1995; Rook, 1997) .

Overall, pain is an aspect of patient care that consumes large amounts of health care resources. For example, recent estimates of the annual cost of chronic pain in Canada are in excess of 10 billion dollars, based on direct care costs, not including the less quantifiable costs of quality of life and productivity (Chronic Pain Association of Canada, 2003). Notwithstanding the impact of pain on both economic and human conditions, studies continue to demonstrate that pain management approaches are consistently underutilized, as patients and caregivers both underreport and under-value the experience of pain (Chow et al., 2001; Johnston, Collinge, Henderson & Anand, 1997; Moulin, Clark, Speechley & Morley-Forster, 2002) .

The focus of the following section is on the factors influencing effective pain management in wound care. As well, a review of the etiology of chronic wounds is provided as a background to demonstrate why pain management in wound care is essential. Gaps in the literature will be discussed.

Introduction to Chronic Wounds

A chronic wound is associated with both systemic dysfunction (e.g., lack of mobility, incontinence, poor nutrition, impaired circulatory status), and specific medical conditions (e.g., congestive heart failure, diabetes). Commonly, chronic wounds, also called pressure ulcers, decubitus ulcers or bedsores, result from occluded supply of blood to tissue, creating stasis and tissue necrosis. Ulceration of the skin and underlying tissues is thus caused by prolonged pressure over the affected area. These ulcerations usually occur over bony prominences such as heels, the coccyx area of the buttock and even the back of the head (Andersen, Jensen, Kvorning & Bach, 1982).

Development, evaluation and widespread acceptance of pressure ulcer risk assessment tools such as the Braden Risk Assessment Scale (Braden & Bergstrom 1996), as well as the use of appropriate evidence-based moist wound healing techniques, have all impacted positively on outcomes in management of decubitus ulcers (Frantz & Gardner, 2001). There are numerous practices such as measurement of the wound area, visual assessment and physiologic assessment (e.g., ankle-brachial index), which have been tested and refined to provide consistency. These practices are reflected in evidence-based guidelines, such as those developed by the National Pressure Ulcer Advisory Panel (NPUAP) (2000) and the Registered Nurses Association of Ontario (RNAO) (2004).

Several protocols have been developed to provide standardized staging for pressure ulcers. The protocol developed by the NPUAP (2000) is the one most familiar to nurses (see Fig. 1). A pressure ulcer is staged from I to IV. While it is common that a Stage I ulcer is considered to be less complex in terms of healing potential and treatment options, each ulcer reflects the individual patient's condition. An 'uncomplicated' pressure ulcer typically heals within three months, while complicated pressure ulcers can remain problematic and require active treatment for many years. Not only does this create resource burden (financial and human), it takes its toll on the patient who must live with the pressure ulcer and the treatment regime, sometimes for life.

Fig. 1. Stages of pressure ulcers

Stage I nonblanchable erythema of intact skin

Stage II partial thickness skin loss involving epidermis and/or dermis

Stage III full thickness skin loss involving damage or necrosis of subcutaneous tissues that may extend down to, but not through, underlying fascia

Stage IV full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone, or supporting structures

Definition from the National Pressure Ulcer Advisory Panel (NPUAP), 2000.

Chronic Wounds and Older Adults

Despite the availability of reputable and reliable assessment tools, pathways, and clinical guidelines, pain management within the wound care arena remains a challenge (Eager, 2002), especially for older adults. Older adults are particularly susceptible to the development and persistence of chronic wounds and their negative sequelae (Guenter, et al., 2000). For example, an 85- year old woman with long-standing diabetes, arthritis and congestive heart failure, admitted to hospital because of pneumonia, would be a likely candidate for a pressure ulcer in the sacral area. Her age along with her chronic illnesses (particularly diabetes) will affect her circulatory system. In addition, poor nutrition will decrease the body's ability to regenerate tissue and maintain skin turgour. Her parchment-paper thin skin covering bony prominences combine with lack of mobility to break down skin and rob tissue of blood-flow. Thus, a pressure ulcer is created.

The Impact of Pain on Wound Healing

If the ulcer is painful due to its location over a bony prominence and/or infection, it will hurt when the patient moves in bed or when trying to get up to a chair. She will then find comfort in lying still, which maintains pressure on the sacral area. In addition, this increases the potential for pressure ulcer development in other areas of her body (e.g., heels, elbows, shoulder-blades, back of the head). If she cannot get up easily, she may have episodes of incontinence. She may then be put in an adult diaper, which will create a moist, acidic environment conducive to skin breakdown. With decreased mobility, she also may lose her appetite (which may have been poor already).

The pain itself may make her feel queasy or anorexic. Nutritional deficits (lab values of albumin, pre-albumin and serum zinc) will diminish her body's ability to heal. Her on-going discomfort may cause sleep disturbance, leading to fatigue. Feelings of dependence and helplessness may increase. She may be at risk of becoming depressed.

Together, these challenges create barriers to wound healing, and can exacerbate pain at dressing change. For example, if the patient feels dependent and helpless, he/she will be more likely to passively accept pain as unavoidable and "not bother" telling the nurse that a dressing change is causing pain. By the same token, the nurse may avoid exploring the issue of pain at dressing change because he/she is pressed for time. If the information is not volunteered by the patient, it stands to reason from the busy nurse's perspective that the pain is under control and does not require any specific thought or action.

As well, dressing changes are repetitive in nature. Thus, a patient who experiences a painful dressing change once, will be expecting the same thing at the subsequent dressing change (Melzack, 1999). The act of simply touching the dressing can elicit a flinch or groan from a patient who has had previous painful dressing changes (Newell, 1999).

Wound Care and Pain Management

This scenario, though common, is unacceptable by today's standards. It is now accepted that poorly controlled pain can slow down the healing process in an existing ulcer, or contribute to the development of skin breakdown in an at-risk individual (Collier & Hollinworth, 2000; Rook 1997;). Consideration of pain management is essential in the healing cycle: if one looks at the effect of stress on healing, it is clear that the experience of pain creates the stress cascade: increased shallow respiration, tensed muscles, decreased blood flow to extremities, increased sensation of pain. Decreased blood flow affects the ability of the body to transport oxygen to the affected area, thus slowing the healing process (Krasner, 1995).

Pain management is described as " the elimination or control of pain, with a goal of restoring comfort, quality of life and the capacity to function as well as possible, given individual circumstances and the source of the pain " (National Advisory Council on Aging , 2002). Despite the fact that pain processes have been articulated for over two decades (Melzack, 1982), and effective medications are available, it is evident that many physicians and nurses still do not seem to know best practice applications for wound care.

Available resources are often used inconsistently or inappropriately, or ignored completely. Patients, particularly the elderly, report that their pain is frequently under treated (Herr, 2002; Lamberg, 1998). In a study of 225 Coronary Artery Bypass Graft (CABG) patients, pain was identified as moderate to severe, yet nurses only provided 47% of patients' prescribed pain medication. Patients in this study did not perceive nurses as resources or as attending to their pain (Watt-Watson, Garfinkel, Gallop, Stevens & Streiner, 2000). In several major surveys conducted in the U.S., one in four individuals felt that their pain had been inadequately controlled in hospital (Hansen 2000). Nurses frequently estimate patients' pain inaccurately, and overestimate the degree of pain relief achieved by medication (Choiniere, Melzack, Girard, Rondeau & Paquin, 1990). In addition, research also indicates that patients report persistent moderate to severe pain following discharge from hospital, with minimal effort on the part of the health care providers to address the issue (Collins & MacDonald, 2000).

Chronic Wounds and Values

The provision of pain relief at the right time with the right techniques and targeting the right clinical outcomes continue to be undervalued by many nurses, despite the plethora of literature in support of attention to these issues. In addition, regardless of best intentions, caregivers may pre-judge or make assumptions about patients' behaviour based on internalized attitudes and values (Ducharme, 2000). For example, the unkempt rowdy patient with a history of alcohol abuse may be identified as 'drug seeking' if she loudly and frequently demands medication for pain, or an individual who has had limited formal education may be quickly dismissed as 'simple' and less effort paid to explain treatments. Elderly or confused patients may be expected to have less sensation of pain than younger more cognitively intact individuals, and may be thought of as over-reacting to the removal of dressings.

While the values of caregivers are influential in determining treatment processes and outcomes of pain management, patients' values are also relevant. Asked to describe the impact of pressure ulcers on their lives, respondents in a qualitative study described pain, grieving, and the psychosocial impact of their ulcer on their lives (Langemo, Melland, Hanson, Olson & Hunter, 2000). These descriptions would seem consistent with the experience of elderly patients, who form the largest cohort of individuals with pressure ulcers.

The elderly patient tends to be marginalized, whether at home or in hospital or long term care setting (Herr, 2002). Pressure ulcers are characteristically chronic conditions, sometimes persisting for many years. The ulcer becomes marginalized as well as the patient, and treatment is often relegated to the 'same old same old'—old being equated with no longer a challenge, no longer of interest or value (Wientjes, 2002). For example, a study of 32 patients with ulcers from Stage II to IV identified that 87% had pain in relation to their pressure ulcer, yet only 6% reported receiving any form of analgesia to deal with the pain (Szor & Bourguignon, 1999).

The ease with which pressure ulcer treatment can be compartmentalized as a functional task, to be completed as quickly as possible, contributes to a further separation of pain from the experience of the whole person. The Total Pain Model used in cancer pain management (Librach,1997) could be an approach to wound care that might enable both care provider and patient to recognize the somatic, psychological and environmental surroundings that impact on the care of the wound. However, this requires development of more than a function-driven relationship between patient and nurse. The holistic assessment approach, which includes pain assessment, is frequently ignored since the dressing change is often seen by both patient and nurse as an isolated task to be completed (Hawkins, 2003).

Ongoing Challenges

There are numerous ongoing challenges to optimal interaction in which nurse and patient express and address pain management issues effectively. One of the major barriers to effective pain management has been the attitudes and behaviours of health care providers, as described previously, who consistently under-assess and under-document pain. (Bowman, 1994; Clarke, French, Bilodeau, Capasso, Edwards & Empoliti, 1996). In addition, lack of knowledge is a hindrance to providing appropriate pain management (McCaffery & Ferrell, 1997). A review of relevant research literature supports this view, in describing the increased use of pharmacological and non-pharmacological pain treatment strategies by more experienced and knowledgeable nurses (Abu-Saad & Hamers, 1997). Although pain management was identified as an important factor in wound healing and improved quality of life in a recent systematic review of the literature regarding treatment for venous leg ulcers, few of the reviewed studies were found to actually include effective pain management strategies (Heinen, van Achterberg, op Reimer, van de Kerkhof & de Laat, 2004).

The patients' perspective of pain and pain management is also important to understand. Many patients believe that they can become addicted to analgesics or are reluctant to use them because of potential side effects such as nausea or constipation. In a study of post-operative patients, Beauregard, Pomp and Choiniere (1998) found that 62% of patients felt they could easily become addicted to pain medication and nearly half of the group felt that it was easier to tolerate pain rather than suffer from the side-effects of analgesics. These concerns, which led to patients' refusal to use medication to manage postoperative pain, have been demonstrated in other studies (Abbott, Gray-Donald, Sewitch, Johnston, Edgar & Jeans, 1992; Lavies, Hart, Rounsefell & Runciman, 1992; Oates, Snowdon & Jayson, 1994; Ward et al., 1993).

It appears that fear of analgesia, especially opioids and narcotics, is problematic for both nurses and patients. Lack of information and mis-information creates a climate where appropriate medication may be refused by the patient or not offered by the nurse, with no opportunity to successfully explore the issues. The research literature indicates that underestimating patients' pain, minimizing requirements for analgesia, and lack of awareness of different methods of pain relief, are common and widespread practices amongst nurses (Buckley, 2000; Hunt, 1995; Lloyd & McLauchlan, 1994). It would seem that ensuring a mutually satisfactory outcome regarding pain management requires attention to a relationship that enables the nurse to provide what is best for the patient and the patient to be authentically empowered to achieve his/her goals regarding care. (Hallett, Caress & Luker, 2000).

Systemic issues can also erode the relationship between care providers and recipients, with dire consequences for pain control. For example, in a study of the pain assessment and management practices of surgical nurses, it was found that barriers to effective pain management related to interruptions during patient care episodes, nurses' attentiveness to patient cues of pain and their interpretation of these cues, and the competing demands of other nurses, physicians and patients (Manias, Botti, & Bucknall, 2002). The current climate of healthcare shortages can cause patients and nurses to feel that they are caught in a de-personalized system, as beds become more important than the individuals who are in them and budgets appear more important than quality of care.

Under these pressures, both patient and health care provider may withdraw from establishing a therapeutic relationship. When this occurs, the wound may become isolated from the context of the whole person. Thus the act of changing the dressing may become a task to be completed as expediently as possible with as little personal interaction as possible.

Changing Practices

A large survey on pain in wound care conducted in Europe and North America, found that while nurses identify that pain management is an important factor in wound care, particularly at dressing change, approximately 50% did not know of products to use that would decrease wound pain/trauma. This has implications for consistent use of pain management plans, since it follows that if nurses are not aware of appropriate treatment options, they are less likely to articulate a plan of care, and rely on whatever is close at hand (Hollinworth & Collier, 2000). Formal education is one route through which students, nurses, and physicians can learn about current, evidence-based wound treatment protocols and pain management.

Increased dissemination of best practice guidelines is another mechanism for enhancing practice. However, in the absence of generally available guidelines and expectations for their implementation, treatment in chronic wounds may be left to the experts on the pain team or the wound care specialist, which may inhibit the need for relationship building between bedside nurse and patient in the assessment and management of pain in wound treatment. While specialist expertise is valuable, it cannot replace the bedside nurse's rapport with his or her patient. However there is much the specialist can do to foster a collegial, learning environment that supports the bedside nurse in developing confidence in his or her own abilities in wound care management (Fox, 2001; Harker, 2001).

Change in practice can certainly occur through education and experience within clinical practice. However doctors and nurses, when left on their own, tend to do as they have been trained, which is, underestimate and under treat pain (Hollinworth 2002; McCaffery, Ferrell & Pasero, 2000). Change in behaviour or practice may require the external hand of professional accountability. For example, once the use of car seat belts was legislated in Canada, mortality from motor vehicle accidents dramatically decreased. Perhaps this type of approach using legally sanctioned consequences might assist in molding the behaviour of health care practitioners.

With national accreditation standards including pain management, administrators may be more inclined to pay attention to ensure that their patients have the right to pain management and pain control (Herschman & Wasserman, 2002; Pillemer, 2001). The adoption of pain as the fifth vital sign in the United States, and the recent addition of pain assessment and management to the Canadian Hospital Accreditation standards both include statements regarding the expectation of regular assessment and documentation of pain. These directives provide the external structures that may encourage health care providers to pay appropriate attention to this issue (Phillips, 2000). With these expectations, nurses are now even more clearly accountable for the measurement, documentation and management of pain, to the extent that by not attending to pain, a nurse places him/herself into a situation where liability may become an issue.

While there have been no reported cases of malpractice suits in either the U.S. or Canada as a result of negligence relating to pain specifically in wound management, there have been two major cases in the U.S. where nurses, physicians and institutions have been found liable for under-treatment of pain (Pasero & McCaffery, 2001) and patients' families awarded millions of dollars. The amount of the awards, in one case, $15million dollars in compensatory and punitive damages (Frank-Stromborg & Christiansen, 2000), sends a strong message that society, reflected in the court decisions, places significant value on a person's right to pain control. This should be seen as a wake- up call for nurses and other health care professionals who provide wound care. "Perhaps the outcome of 2 legal cases…might finally persuade the medical community that its duty to relieve pain and suffering is not only an ethical one but is enshrined in law"(Rich , 2001, p. 151).

Despite the potential risk of legal action, the current wound care literature still reports less than stellar improvement in wound care pain assessment/management (Moffatt, Franks & Hollinworth, 2002; Reddy, Kohr, Queen, Keast, & Sibbald, 2003; Szor & Bourgignon, 1999). However, once a generation of physicians and nurses has experienced the consequences of legislated accountability to include pain assessment and treatment as part of the expected patient care process, perhaps there will be an improvement in patient comfort and an attendant improvement in quality of life for patients with chronic wounds.

In the meantime, patients continue to experience chronic wounds and the pain associated with them. As the large international survey of wound care nurses indicated, wound pain is primarily associated with dressing changes (Moffat et al, 2002). Current literature appears to support the notion that it is primarily within the purview of the nurse to initiate assessment and treatment strategies to deal with pain at dressing change, yet despite standards, guidelines, education, availability of appropriate and effective treatments, patients continue to report pain. Thus it would seem that there is something else impacting on the nurse's ability to integrate into clinical practice the recommendations of the literature and expectations of the profession. It was the quest for this unknown factor that prompted this study.

To move nurses to think of pain management as they walk through the door to care for a patient with a chronic wound, it is important to understand what the experience of changing a dressing is like for the nurse him or herself. Standards, education, and treatments are only useful if they are mobilized and used appropriately. It is hoped that this study will illuminate some of the unique and special aspects of changing a dressing which will assist in heightening other nurses' awareness of the needs of patients with chronic wounds.

Chapter Three: Methodology

Wound care is an activity in nursing that has multiple components. It involves not only the physical task of changing or applying a dressing but the need to assess the physiological and psychological parameters of the patient's condition. The previous chapter explicated the ideal ways nurses are expected to conduct dressing changes and much has been written about the expectations inherent in the task. However, observation of nurses carrying out the task of changing a dressing would indicate that this does not always occur. Missing in the literature on the topic is discussion of nurses' practices around dressing changes, which are little understood or explored. Nurses' actions impact profoundly on wound healing and patient quality of life. Thus it is important to understand how nurses' experience dressing changes to comprehend the nature of dressing changes in nursing practice. While there are multiple research approaches to knowledge generation, phenomenology offers a way of understanding what changing a dressing means in nursing practice that can reflect the context, life processes, tacit understandings and social meanings that are powerful components of the provision of wound care.

Phenomenology is an approach that allows exploration of individuals' experienced relationships with the world, to understand the meaning of phenomena as completely as possible. It is the living, breathing, real world as it is experienced that is explored, and it is the descriptions of this experience, bracketed and taken out of the every-dayness of living, that enables us to investigate and learn about the meaning of the phenomenon (van Manen, 1997b). When time is taken to step out of the every-day, to hold the event out, and look carefully at what is there, the meaning of the experience resonates with what is familiar but extends understanding beyond the familiar to a renewed view of the phenomenon.

Quest for a Methodological Approach

Nursing is a discipline that encompasses the bio-psychosocial-spiritual complexities of human beings, living within a multi-dimensional world. These complexities can have intense meaning and impact on the person at micro, meso and macro levels.

A chronic wound, for example, is of concern for the patient as a physical problem that requires frequent attention, usually from a care-giver rather than the patient him/herself, and dressing changes. There may be odour, exudate, pain and/or infection, which, as well as hindering wound healing, may create a sense of the person being unclean. The location of the wound may inhibit mobility, so the individual's potential for activities of daily living, including interacting with others, diminishes. The chronicity of the chronic wound is frustrating, as healing often seems an unattainable goal -- some patients have such wounds for years -- and patients can become exhausted and depressed from the continued lack of progress in wound healing. In addition, the family and community suffer with the patient because the sick role is prolonged and attention is, of necessity, focused on the daily wound dressing regime.

Thus, the micro level of chronic wounds contains the wound itself, which involves the impact the wound has on the individual as the thing requiring treatment, observation, and management. The meso level can be identified as the relationship of the patient with those around him/her. Interactions with health care providers (physicians, specialists, nurses, physiotherapists, occupational therapists, and social workers) are concerned with the ways the larger circle of patient and significant others cope with wound treatment. The macro level is focussed on the larger system issues that impact on the individual with a chronic wound. For example, there are often application forms to be completed to receive special benefits in long term care or community settings, the use of funded transportation services to attend clinics, drug benefit and insurance plans to assist in coverage for non-formulary drugs. In addition, since the on-going health care needs of individuals with chronic wounds often relegate them to a non-productive status, they may be perceived as being a drain on society.

The intricacy of these overlapping layers can be either teased apart and separated to address distinct issues, or examined as a whole to take into account the essential relatedness of each component. Each of these approaches can be used to come to a more profound understanding of the experience of chronic wound care. In the following section, hermeneutic phenomenology will be described as a methodology which enables the researcher to both tease apart and bring together the elements of wound care leading to an understanding of the meaning of the experience of providing wound care.

Hermeneutic Phenomenology

Hermeneutic phenomenology provides an appropriate approach to nursing research that is responsive to the human-ness of lived experience (van Manen, 1997). Hermeneutics was originally the study of biblical and theological interpretation. The term, first coined in the 17th Century, is derived from the Greek verb *hermeneuein*, meaning to say or interpret skillfully; the noun *hermeneia*, which is the utterance or explication of thought; and the name *hermeneus*, which refers to Hermes, the messenger of the gods, responsible for bringing dreams to mortals (Hunter & Morris, 1899; Moules, 2002; Smith, 1994).

In this study, hermeneutic phenomenology provides the opportunity for the researcher to engage in reflective analysis of the descriptions of nurses' experiences of changing a dressing. This interpretive process is a way of bringing forth a textual expression of the reality of changing a dressing that has resonance with the reader's lived life and by doing so, renders it meaningful. Because the very nature of understanding is ephemeral, use of a variety of approaches, such as poetry, art or prose, helps deepen our perceptions (van Manen, 1997b).

Photographs of wounds have been used in this study as a way of providing the reader with some sense of the reality of chronic wounds. Images of wounds alone were deliberately selected as a way of demonstrating the impact of the wound itself on the nurse. While the context of the wound includes the whole patient and the environment in which the patient is situated, it is the wound itself that draws the nurse in.

The Nature of Phenomenology

Phenomenology emerged as a philosophical approach of interest in Europe in the early 20th Century, with the writings of Dilthey, Husserl and Heidegger, who sought to explain the world in the context of human lived experience. Dilthey (1833–1911) described a 'human science' (*Geisteswissenschaften)* (Dilthey, 1883/1989) which was distinct from the 'natural sciences'. In particular, he viewed human science as the dynamic meaning of life experiences, which required interpretation (hermeneutics) rather than observation (causality). It is from Dilthey's writing that the term, lived experience became understood as a fundamental assumption of phenomenology.

A mathematician, Husserl (1859-1938) expanded on Dilthey's work to describe human science. It was Husserl's contention that objective truths, such as those found in logic and mathematics, originated in living acts of human consciousness which existed prior to the determination of these objective truths. In order for these acts to be truly understood, they need to be taken back to an elemental meaning which is somewhere between full conscious awareness and complete lack of awareness (Kearney, 1986). In other words, an act of human consciousness must be disentangled from the typical ways of thinking to return to the unspoiled purity of the initial encounter with it (Spiegelberg, 1982).

Intentionality

Husserl explained the structure of consciousness in terms of intentionality (1907/1964). Intentionality has been described as aboutness (Dennett & Haugeland, 1987) or a way of differentiating the object from the meaning the object holds. Brentano, a 19th Century philosopher, viewed intentionality as the way of drawing a distinct line between physical and mental phenomena — only mental phenomena are capable of existence in an intentional way. In other words, intentionality takes the object and imbues it with a sense of meaning that exists whether the object itself is real or imagined. Thus, our relationship with the world has intent; all thought has consciousness already within it (van Manen, 1997b).

In this study, the notion of intentionality means that it is recognised that nurses' understandings of changing a dressing are not bound only by the physical act of providing actual wound care, but also by their assumptions and preconceptions of the world. I seek nurses' descriptions of, and their thoughts and feelings about, changing a dressing.

The Phenomenological Reduction

In order to come to an understanding of the phenomenon in question, Husserl (1913/1973) argued that objective interpretation is possible by bracketing the subjectivity inherent in the interpreter's own world. Husserl's phrase "to come back to the things themselves" (*zu dem Sachen selbst*) was the corner-stone of this stance (cited in Kearney, 1986, p. 13). Bracketing in this way is similar to the use of brackets in a mathematical construct, where the bracketed portion of the problem is the first operation. Thus, Husserl advocates that the phenomenon should be approached without theoretical presuppositions or constraints so it may be seen anew as "the thing itself" rather than being obscured by our subjectivity. This process, known as the reduction, is accomplished by examining the phenomenon within a purely cerebral realm, to see it independently from the elements in the world that confound it: "In order to see the world and grasp it as paradoxical, we must break with our familiar acceptance of it" (Merleau-Ponty, 2002, *xv*).

Husserl's student, Martin Heidegger (1889-1976), argued that bracketing in this way was not possible since it did not reflect the reality of human experience. Heidegger (1962) proposed instead that phenomenology itself is the understanding of the real world, which cannot be bracketed because the interaction within the real world is in fact what creates it. Malpas (2003) asserts that Heidegger's approach to understanding being- in- the- world (*Dasein*) requires experiential engagement with the world, not the transcendent phenomenology espoused by Husserl.

Merleau-Ponty (1909-1961), a French philosopher, stated that experience can not be separated from the act of living through the experience (Merleau-Ponty, 1945 / 2002). His philosophic focus on perception placed embodied consciousness at the centre of all thinking. The body's being- in- the- world assumes the body's role as a medium through which consciousness lives and breathes. This primacy of perception is the background from which all subjective and objective modes of action stand out. Perception is not simply the result of the impact of the external world on the body. Even if the body is distinct from the world it inhabits, it is not separate from it. Thus there is no abstract universal perception; there is only perception as it is lived in the world (Merleau-Ponty, 1945 / 2002).

Merleau-Ponty (1945 / 2002) asserts that perception alone is limited to description, meaning that one can only describe what one perceives and not interpret it. Heidegger disagrees with this perspective however, and interpretive phenomenology is, in Heidegger's terms, fundamental to the phenomenological endeavor (1962). It is through the process of hermeneutic inquiry that the researcher seeks to know the meaning of the phenomenon as it is experienced and understood by the individual (van Manen, 1997b). However the very nature of interpretation is fraught with potential traps, which consist of the assumptions we make, our biases, and the sum of our own life experiences which colour our view.

In other words, the researcher's own bias may cloud their ability to perceive the phenomenon as it truly is.

Husserl (1907 / 1964) described phenomenological reduction as a way of bracketing all one's presuppositions, leaving the experience in a form that could then be purely examined. In other words, since the mind can explore imaginary as well as actual objects, the question of factual existence of the object under consideration could be bracketed or set aside. However this view, which suggests suspending existence, is not supported by Heidegger or Merleau-Ponty. Their view of reduction or bracketing recognizes that reduction involves deliberate manipulation to control for, but not to expunge the position of the object's existence within the world. Indeed, the elements that can be identified as assumptions, knowledge, and past experience are all links that are made explicit through the act of reduction. Phenomenology therefore involves a careful deconstruction, much like the work of the archeologist that painstakingly removes the layers of civilization to come upon the item itself, which has been hidden from view.

Phenomenological reduction (or *epoché*) is the process of attempting to neutralize one's limited view or biased assumptions of the phenomenon in order to be able to freely reflect upon the ways in which the phenomenon in question is known and experienced (Crotty, 1995). This reduction, or peeling back of layers, enables the researcher to return 'to the thing itself', to re-interpret and reconstruct the experience without the overlay of bias. Van Manen (1997b) describes reduction through various levels, providing an approach that permits the researcher to set aside conditions and expectations to experience the phenomenon in question as it truly exists. It is this form of the reduction that has been implemented in this study.

Awakening of Fundamental Amazement

Van Manen (1997b) describes the first level of reduction as an initial step of recognizing that one has an abiding interest in discovering the meaning of the phenomenon in question. As an Advanced Practice Nurse learning about wound care, I was eager to develop my skills in a way that would not only improve the physical wounds but also address the suffering experienced by patients with a chronic wound. Discovering the impact of pain on wound healing and the management techniques to decrease pain provided me with a care giving role that was and is deeply satisfying. But my observation of others providing wound care did not always appear to reflect this view. Often the approach seemed to reduce the dressing change to a perfunctory physical task. But as I began to write about wound care within a phenomenological context, I began to realize that my view of others and even of myself in my role as nurse was to some extent the result of the overlay of my assumptions, beliefs, and biases about nursing, about patients and about wound care. If I really wanted to understand what changing a dressing means for nurses, I needed to let go of my preconceptions and search for the essence of the experience with nurses themselves.

Van Manen (1997b) writes about the need to first become engaged and entranced by the phenomenon in question. The dissonance between my approach and what I was observing in others made me wonder about the fundamental nature of changing a dressing. What does this experience mean to other nurses? Does changing a dressing have an impact on how they perceive themselves as nurses?

The questions raised by this phenomenon have propelled me on this path. I am interested in understanding the perspective of other nurses to understand the phenomenon of dressing change, and identify the things that nurses find important within the act of changing a dressing in a way that will provide resonance for others involved in wound care (van Manen, 1997a).

Overcoming Subjectivity

As van Manen (1997b) points out, in the quest for a deeper understanding of the meaning of lived experience, it is human nature to attempt to ascribe patterns or frameworks to provide ready-made explanations. The questions and resulting dialogue that have been stimulated by this search are linked to the time, culture, and environment in which they are created. In order to ensure that these explanations are not a skewed justification or the result of one particular point of view alone, the subjective biases surrounding the phenomenon in question must be identified.

It is not easy to discover one's entrenched views are biases. Just because I feel that professional satisfaction results from the interplay of the art and science of nursing, it does not mean this is a view espoused by all nurses or indeed is the only right way to define nursing. There are numerous examples in the literature of how nurses in the workplace identify job satisfaction with workload acuity, physical demands of the job, and supervisory support (Adams & Bond, 2000; Bryant, Fairbrother & Fenton, 2000; Larabee , Janney, Ostrow, Withrow, Hobbs & Burant, 2003). Nurses do not necessarily see themselves as holistically therapeutic care givers; in fact nurses have described themselves in terms of workers who are there for the shift and to provide safe, competent care of patients (Sengin, 2003).

In addition to my belief that nursing is a holistic combination of art and science, I believe that nurses are autonomous in their practice. There are legal restrictions on the autonomy of nurses regarding what they are legally sanctioned to do or not do. However, nurses are capable of, and indeed expected to be able to think critically and make decisions regarding the nursing aspects of patient care (Canadian Nurses Association Code of Ethics, 2002). For example, care of chronic wounds (other than deep surgical debridement) is within the scope of practice of registered nurses in Canada. However, because common practice has been for physicians to write orders for dressing changes, both physicians and nurses have come to believe that wound care requires medical orders.

In spite of my understanding of the autonomy of nursing practice around wound care, there is a powerful belief based in the reality of past practice and still held by nurses, physicians, and patients that it is the physician's role to make decisions around wound care. Even though my perspective of the autonomy issue may be legally correct, it is still contrary to current practices and, as such, remains an interpretation that is not held by the mainstream of nurses. It is thus important to recognize the existence of my pre-conceptions in order to come to terms with how an individual's view of autonomy influences his/her experience of changing a dressing.

This process of peeling away the layers of assumptions, pre-conceptions and beliefs has afforded me the challenge and the opportunity to examine my assumptions about the nurse/patient relationship. Although the literature points to the value of the therapeutic relationship on patient outcomes (Lindahl & Sandman, 1998; Melnechenko, 2003; Wilkin & Slevin, 2004), this may or may not be the belief held by all nurses. In fact, as Gadow (1980) points out, the expectations of both nurse and patient may in fact block opportunity for this level of connection to occur. Emotional distancing has been described as a characteristic of the professional relationship that should be in place to ensure therapeutic boundaries are maintained (Briant & Freshwater, 1998; Nadelson & Notman, 2002; Sines, 1994). Thus, although my perspective may be that attention to the interpersonal therapeutic relationship is an integral part of changing a dressing, other nurses may not have the same approach. This does not infer that the care provided by them is any less appropriate than the care I provide. It demonstrates that the experience of engagement has different meanings for different nurses. However, what is important is that I, as researcher, recognize where my pre-conceptions and biases can distort or influence the ways the experience of changing a dressing is understood within the study (van Manen, 1997b).

Numerous authors have addressed the issue of researcher bias and have provided recommendations to modify this problem (Cutliffe & McKenna, 2002; Horsburg, 2003; Norris, 1997). Suggestions such as maintaining a personal log or journal during the research process, eliciting the views of study participants regarding validity of interpretation, and on-going dialogue with colleagues to challenge and critique assumptions have all been used to ensure my own biases are noted and set aside as far as is possible.

In summary, the methodology for this research is based on hermeneutic phenomenology, guided by the writings of van Manen (1997b). The notion of intentionality and the phenomenological reduction outlined by van Manen are the research protocols that will be implemented.

Methods

Participants in the Project

Wound care is a component of many patient care settings, and dressing changes are part of the daily intervention plans for many nurses. The level of expertise regarding wound care varies. To understand the experience of dressing changes, it was important to seek out nurses whose practice includes wound care on a regular basis. Their perceptions reflect the realities facing nurses across the continuum of care since nurses must incorporate dressing changes into the totality of their patient care obligations during a regular workday. To this end, nurses from acute, long term and community care environments were invited to participate in the study. Six nurses from each of the care environments participated in the interviews and it is their words that have been transcribed and used within the body of this thesis.

For the purpose of this study, which is based on conversational, in-depth interviews, participants needed to be able to describe dressing changes and chronic wound care. Hermeneutic phenomenological research is a method of constructing interpretations about the nature of a specific phenomenon in human experience that brings forward a deeper understanding of the meaning of the event. Van Manen (1997b) asserts that the interview provides an opportunity for "collaborative hermeneutic conversations" (p. 99) between the researcher and participants. In this approach, the researcher initiates the dialogue, but is guided by the participants' description. It is the depth and breadth of the individual participant's lived experience of what it is like to change a dressing that was of interest to me as a researcher.

The transcription of the interviews were used to derive a "narrative of experience" (Caelli, 2001, p. 278) from each interview, using the participant's own words as much as possible. This narrative provided a summary of key elements of the interview, which was used as a method of distilling themes. Participants were contacted by telephone and/or email to review their narrative which gave an opportunity to validate the initial interview and provide clarification if required. Through this process of dialogue and discussion, additional insights may be offered and the researcher's analysis is enriched (Haggman-Laitila, 1999).

As mentioned above, nurses who agreed to participate in this project were regularly involved in the actual, direct provision of wound care. The phenomenological approach of this study required the participants to be able to speak with an authentic voice regarding this topic. These individuals were comfortable with the skill level of dressing changes and typical patient care within their setting, beyond the pragmatics of basic nursing skills. Thus, the selection of participants for this study was based on the following: 1) registered nurses who have had a minimum of one year's experience providing direct wound care to patients; 2) able to describe their experiences of providing wound care and willing to share these experiences with the researcher; 3) equal numbers selected from acute care, long-term care and community care, to reflect the clinical practice realm for wound care ; 4) able to speak and read English.

Sample

In qualitative research, participant selection provides opportunities to illuminate the phenomenon being studied (Polit & Hungler, 1999). While there is no standardized formula to determine sample size in qualitative research, the number of participants should reflect attributes relevant to the phenomenon being studied (Sandelowski, 1995; Yardley, 2000). In addition, the sample size should be manageable in regards to the amount of data collected, since the transcribed interviews provide an abundant source of material to be analyzed by the researcher (Sandelowski, 2001).

For the purpose of this study, nurses from acute, long term and community care were invited to participate in the study. A sample of 18 participants was selected from the three areas of practice. Due to staffing ratios and policy/procedural differences amongst the three areas, nurses across the continuum of care may provide dressing changes in different ways. Thus each area was equally represented in order to include participants with a variety of approaches and experiences in the provision of wound care.

Participant Profiles

Demographic data were obtained from participants, such as age, length of time in nursing, educational preparation and employment status which provides a general description of the backgrounds of the participants in this study. Six registered nurses from each setting (long term, acute and community care) participated in the study, for a total of eighteen. The nurses were all female, between the ages of 25 and 60. The majority had worked in one setting for most of their career, although several of the nurses working in community and long term care had begun their careers in acute care settings. Only one nurse (Joanne) had been a nurse for just over a year, but had previous experience providing wound care for several years as a Registered Practical Nurse (RPN). The majority of the nurses participating in the study had five to ten years nursing experience and most had at least that amount of experience providing wound care. Several of the nurses had from twenty to thirty years nursing experience.

Two thirds of the nurses were diploma prepared with the remainder Baccalaureate university graduates. Many of the nurses had attended some type of wound care education session (from in-service to workshops or courses) at some time in the past several years. Wound care education has been mandated for Long Term Care facilities as well as for the community care nursing agencies in Ontario, so this was expected. The majority of the nurses in this study were employed full-time, however several of the participants had been full-time but had moved into part-time or casual positions because of preference (e.g., young children).

All of the nurses who participated in the study were English-speaking and had worked for the majority of their careers in Canada. Several of the nurses were originally from other countries and had nursing experience in their home countries as well.

Ethical Considerations

Once the study was approved by the Human Research Ethics Board, Panel B of the University of Alberta and the University of Western Ontario Ethics Review Board, the process of recruiting participants began. Purposeful sampling provides an opportunity to invite individuals who met the inclusion criteria to participate in the study. Through colleagues in long term care, acute care and community care, I was able to access potential participants who were provided with a letter of invitation outlining the purpose of the study and expectations of participant involvement (see Appendix A).

Protection of participants in research is essential in terms of informed consent, confidentiality and anonymity. Because the approach to this study is one that delves into the reality of the practice environment and the experiences of nurses, there must be no possibility of individual identification, so that the participants feel confident that they can speak freely. Participants must feel safe and secure during the research process, from the invitation to participate in the study, through the data collection and analysis, to the discussion and presentation of results. The following sections provide details about the ways this protection was accomplished.

Informed Consent

Potential participants were sent a letter inviting them to participate in the study (see Appendix A) and asked to contact the researcher if they were interested in participation. Those interested in the study had an opportunity to speak individually with the researcher to discuss the project and were provided with an information letter (Appendix B). Questions or concerns regarding the study were addressed at this time and individuals were free to decline involvement in the study if they wished . If the individual agreed to participate, the consent form (Appendix C) was explained and two copies were signed. Both participant and researcher kept a copy. Participants were reminded that they were entitled to withdraw from the study at any time or withdraw all or part of their data, without negative repercussions.

Confidentiality

Involvement in a phenomenological study can be extremely personal as participants divulge thoughts and feelings, which may be of a sensitive nature or reflect negatively on individuals were they able to be identified. Thus, protection of the identity of participants and their patients is essential. Once individuals agreed to participate in the study, a pseudonym was selected which replaced their real name on all raw data, transcripts, and any other information about the study, including analysis and presentation of study results, in any form. It is the responsibility of the researcher to be the sole individual with access to the true identity of participants. Only the researcher, supervisor and the transcriptionist, had access to the transcript data; the transcriptionist signed a confidentiality agreement before she began work on the transcripts. (Appendix D). All of the consent forms, audiotapes, transcripts and any other materials provided by participants are in secure, locked file-cabinet, accessible only by me, and will be destroyed within three years of the completion of the study.

During the research process, participants may share information relating to professional practice that might be considered unethical or unsafe. If this had occurred, I would have discussed the issue with the individual and if necessary, worked with the individual to develop a plan of action. Should the need have arisen (and it did not), I was prepared to direct the participant to the appropriate professional support system.

Data Collection

Data collection involved a minimum of one conversational interview per participant. These interviews lasted from one and a half to two hours and were audio-taped and transcribed verbatim. Initially, two interviews were planned per participant, however it became evident that one in-depth interview sufficiently plumbed the depths of the topic. Subsequent telephone or face-to-face interviews provided an opportunity to clarify and validate what has been transcribed and extrapolated to a narrative description. This afforded the interviewee with the chance to present any additional observations pertaining to the study. As van Manen (1997b) points out, the duration and number of interviews is not fixed, since "the art of the researcher in the hermeneutic interview is to keep the question (of the meaning of the phenomenon) open, to keep himself or herself and the interviewee oriented to the substance of the thing being questioned" (p. 98).

In addition, opportunity presented itself to observe nurses providing wound care as I carried out my role as wound care specialist. These observations were recorded as field notes and kept in a journal that did provide additional data for this project. Although study participants were encouraged to write down any additional thoughts they might have, in a narrative form, this did not occur during the course of the study.

Although personal bias is difficult to remove entirely from the research process, efforts have been made to remove blatant bias from the study protocol. To remain vigilant and decrease the potential for personal beliefs to impact on interpretation, a reflective journal was kept, where my own thoughts, feelings and biases were articulated. Regular discussion with colleagues regarding the journal entries and as the transcripts were interpreted, provided another means of avoiding bias. This accounting of personal perspective is a method of ensuring auditability within the study. Auditability is the way in which the researcher "stays true" to the research process and can provide an audit track which describes the researcher's approach at all times along the research trajectory (Beck, 1993).

Data Analysis

Data in phenomenological research include the interview material, that is, tapes and transcripts, field notes, and journals, but also material explicit of the phenomenon gleaned from literature, poetry, and the visual arts, which may have relevance and give resonance to the study. The immersion of the "researcher as instrument" (Munhall, 2001, p. 629) in the lived experience of the research process requires an open mind, and the ability to see outside of one's own preconceptions and determinations. van Manen (1997b) points out that:

> Making something of a text…by interpreting its meaning is more accurately a process of insightful invention, discovery or disclosure—grasping and

> formulating a thematic understanding is not a rule bound process but a free act of 'seeing' meaning (p. 79).

Thus attention has been paid to the world of art and literature where creative and unexpected events may provide even more opportunities for meaning to surface.

A number of authors have suggested various approaches to use when analysing phenomenological data. While these suggestions provide direction to ensure rigour and consistency within the examination of data, the multi-dimensional aspect of the analysis itself fundamentally underscores whatever approach one takes (Yardley, 2000). For example, van Manen (1997b) provides a framework of temporal, spatial, relational and bodily domains as a way of structuring the descriptions about lived experience.

Van Manen (1997b) provides a thoughtful outline of an elemental methodological structure for hermeneutic phenomenology:

1. turn to a phenomenon which seriously interests us and commits us to the world;
2. investigate experience as we live it rather than as we conceptualize it;
3. reflect on the essential themes which characterize the phenomenon;
4. describe the phenomenon through the art of writing and re-writing;
5. maintain a strong and oriented pedagogical relation to the phenomenon;
6. balance the research context by considering parts and wholes. (p. 30)

Despite this explication of a format, van Manen (1997b) is quick to offer the caveat that "critical moments of inquiry are ultimately elusive to systematic explication" (p. 34). The more subtle aspects of effective phenomenological research need to be embedded or developed within the researcher him/herself; these requisite skills include interpretive sensitivity, contemplative depth, eloquence in writing, and an ability to reflect the authentic voices of others within the work.

The principles outlined above have provided a guide that I believe assisted in ensuring truthfulness and relevance within the study. While prescriptive absolutes are not part of phenomenological methodology, it was essential to know and respond to the signposts in order to avoid becoming lost in the seductive thrill of descriptive lists which would be no more than reactions to an experience (Munhall 2001).

Rigour

The final issue to ensure the rigor of a phenomenological study is to identify the fitingness of the study—that is, the relevance of the study to the larger world (Beck, 1993). Although phenomenological studies are not designed to be generalizable in the same way as quantitative studies, there is still an opportunity to gain from the understanding generated from the in-depth interpretation of lived experience.

Phenomenology is a deeply reflective process. It offers the opportunity to question what it is that nurses do, in a manner that encourages dialogue and discussion. Wound care is one of the most intimate acts performed by nurses. This study has provided nurses with opportunities to explore what the experience of dressing change is like, and reflect on what it means to change a dressing. The data that arise from the interviews may deepen our understanding of this seemingly simple task. As well, it may give rise to thoughts of how nurses experience other phenomena within nursing care.

Significance

This study uses a hermeneutic phenomenological approach to delve into the meaning of changing a dressing for nurses. The significance of this research rests with the opportunity for insightful understanding of the nurse's experience of changing a dressing. The understanding generated by this research may help to solve the disparity between the ideal and the reality of changing a dressing in the clinical practice environment. As well, it may provide nurses (and others) with a better understanding of hands-on nursing and how this direct contact with patients provides nurses with a powerful connection not only with the patient, but with their own sense of themselves as nurses.

Chapter 4: The Wound Itself.

> *"No one has seen what we've seen. Did you see that cavity in Mrs. Claggett's chest after they removed her lung? You could get lost in there, I had to shove my arm in up to my elbow to pack the wound and they hadn't even ordered any pain medication for her, 'cause it dropped her blood pressure. I feel like a member of Hitler's army when I do that dressing"*
>
> *Linda, in A Nurse's Story (Shalof, 2004, p. 110).*

Wounds are part of the "hidden world" of nursing care. As Linda, one of the nurses in *A Nurse's Story* (Shalof, 2004), remarks, unless one is directly involved in the care of patient's bodies and particularly with wound care, it may be difficult to visualize what nurses see and do when they talk about changing a dressing. In order to assist the reader in better understanding the reality of wound care, this chapter contains photographs and descriptions of wounds. While these examples are taken from my own clinical setting (with permission from patients/substitute decision-makers), they are typical of chronic wounds across the continuum of care.

A computer search of health care disciplines literature, using CINAHL, MedLine and JSTOR identifies dominant themes relevant to wound care are focused on the biological nature of wounds, treatment methods and descriptions of the patient's experience of (for example) living with a chronic wound. However, the meaning of wound care in the context of the nurse's work life is not readily apparent. Lawler (1991), Maeve (1994, 1998), Shakespeare (2003) and Parker (2004) all allude to the " chaotic messiness and transgression of physical and social boundaries" (Parker, 2004, p. 212) of nursing. Yet the experiential voice of the nurse on the subject of wound care has not been heard. Within the pages of the next three chapters, the voices of nurses speak of their experiences of wounds, the world beyond the wound and the meaning of changing a dressing.

Manifestation of the wound

A wound is a revelation of the body's failure to retain its integrity. Whether accidental, intentional or surreptitious, the wound itself provides a view of how the body works (or does not work). The next sections of this chapter present background material relevant to a discussion of wound care. This information will give the reader an understanding of wound meaning, historical context and the cycle of healing. The wound itself is an amazingly complex structure that responds from the micro cellular level to tissue repair or degredation visible to the naked eye. "In classical Greece, every cultured layman was supposed to know the basic principles of medicine… I do believe that everyone should know the beautiful deeds of which his or her tissues are capable" (Majno, 1991, p. 1). This chapter will hopefully provide the reader with a perspective of an example of the wonders of the human body.

What is a wound?

A wound is defined as a break in the skin or an organ caused by violence or surgical incision; a casualty to military personnel resulting from combat; a figurative injury to feelings or pride (Hunter & Morris,1899). Wounds can be caused by sudden trauma (e.g., accident, violence), by surgical intervention or by unrelieved pressure to the tissue. When a wound progresses through the sequential reparative process in a timely manner with a return to both anatomical and functional ability and structure, it is described as an acute wound (Sholar & Stadelmann, 2003). Any wound with delayed healing (frequently related to a combination of intrinsic and extrinsic factors) is considered a chronic wound. While the focus of this project has been on chronic wound care, the same principles apply to both chronic and acute wounds.

The Healing Process

The healing process for any wound involves physiological systems directed towards restoration of tissue integrity. Tissue repair at all levels is determined by the state of the systems and the ability to respond to the body's requirements for healing to occur. Conditions for wound healing are optimized when tissue damage and loss are minimized.

Surgical wounds with even, closely approximated incisions are likely to heal without complications provided there is adequate circulation and absence of infection. Acute (surgical) wounds are frequently closed by primary intention (i.e. approximation of skin edges through sutures, etc.).This method decreases the risk of infection, minimizes tissue loss and supports minimal scarring. In some situations, surgical wounds may also be left open for a few days to allow for edema or drainage of fluid to occur, and then the wound is closed with sutures, staples or adhesive strips. This approach is called delayed primary intention or tertiary intention (Hess & Kirsner, 2003).

Wound healing by secondary intention typically occurs in those situations when tissue defects have to be refilled or when pus formation interferes with the direct re-connection of the wound edges. In this case, the wound edges are not adjacent to each other but separated by a gap in the underlying tissue. To close this wound, new tissue must be grown. This granulation tissue forms the structure upon which re-epithelialization occurs. The energy required for the body to accomplish healing in this way is much greater than the energy required for primary intention wound healing. Given that wounds of this nature are often pressure ulcers, the healing time is affected by the individual's concomitant health issues and negatively impacted by the additional strain of energy requirement to produce healing.

Phases of Wound Healing

Irrespective of type or level of damage, every wound moves forward through three interconnected, dynamic phases of healing (Figure 4.1). These phases overlap and healing time is dependent on intrinsic and extrinsic factors such as presence of infection, impaired circulation, poor nutrition, etc. However, the anticipated healing time of an uncomplicated, non-infected wound provides a bench-mark which helps to categorize chronic versus acute wounds. Lazarus et al (1994) provided a classic definition of chronic wounds as those wounds which "fail to progress through a normal, orderly and timely sequence of repair, or wounds that pass through the repair process without restoring anatomic and functional results" (p. 490).

Laurene, acute care:

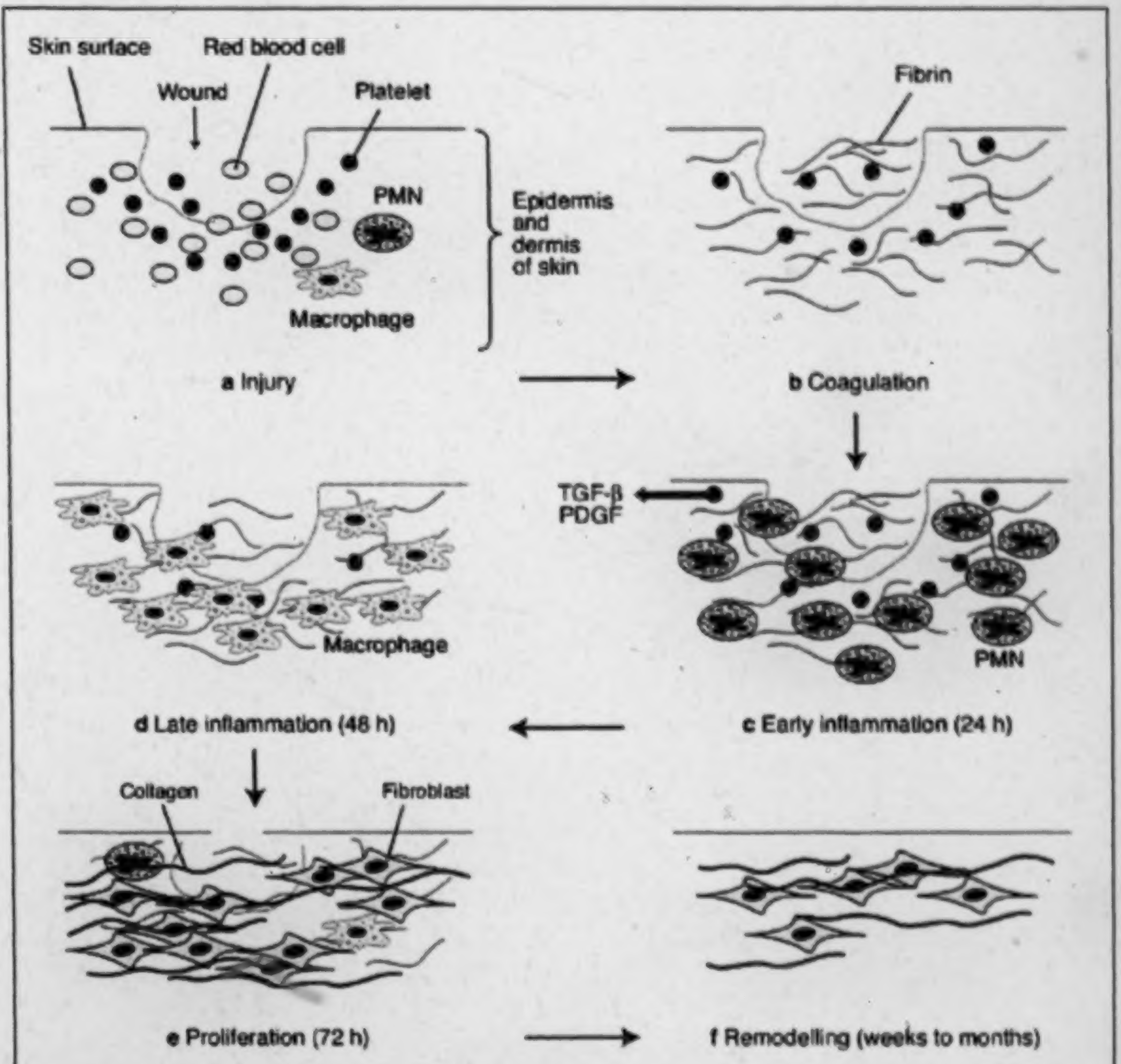
I have always watched surgical nurses and I guess it suits my personality you know quick, something's wrong, fix it up, stitch it up. So then eventually there would occasional surgical incision that might have to be packed and I just always found that interesting to see the healing progression and then they eventually go and get closed secondarily and then just I guess I just found it interesting instead of really repulsive where some people just find it repulsive and not interesting. I found it interesting.

Wound healing begins at the moment of injury and actually continues on for several years as the tissue regains tensile strength. The first phase of the healing process is the inflammatory phase, which lasts from two to five days. Hemostasis and vasoconstriction occur immediately, along with platelet aggregation to provide clotting and the opportunity for the body to begin to approximate wound edges. Kinins and prostaglandins are produced, promoting vasodilation and small vessel permeability in the tissue surrounding the wound. Pain, swelling and edema result from this activity. Subsequently, macrophages enter the wound and are responsible for phagocytosis as they absorb bacteria and tissue debris. As well, macrophages release a number of additional important substances that aid in debridement and wound cleansing. Growth factors (cytokines) are also released by macrophages. These substances are essential in the instigation and proliferation of granulation tissue.

The proliferative phase, lasting for approximately 3-14 days, begins once the wound has been cleaned of devitalized and unwanted matter. In the proliferative phase, granulation tissue is formed in the wound bed. Reconstruction occurs as fibroblasts (attracted to the wound by the cytokines) produce large quantities of collagen which are deposited in seemingly haphazard fashion, but which re-align themselves to adjust to the configuration of the wound and form the basis of granulation. Revascularisation at the deeper levels of the wound occurs at the same time. This process is mediated by cytokines which stimulate growth factors to both proliferate and migrate for both angiogenesis and granulation.

The maturation phase begins almost as soon as this extracellular matrix is established. As the collagen fibres are deposited in the wound bed, they form bundles which provide the healing tissue with tensile strength. As well, the bundles increase the weaving together of tissue as they re-model and re-allign themselves to best approximate the wound edges. This activity results in a decrease of edema to the area and the formation of a collagen scar, which is paler than the surrounding healthy skin. As the re-epithelializing tissue increases in tensile strength and the wound contracts and remodels, this phase can last from seven days to two years.

Figure 4.1: Phases of Wound Healing retrieved May 10/05 from www-ermm.cbcu.cam.ac.uk/ 03005829h.htm


Skin surface
Red blood cell
Wound
Platelet
PMN
Macrophage
Epidermis and dermis of skin
a Injury
Fibrin
b Coagulation
TGF-β
PDGF
PMN
c Early inflammation (24 h)
Macrophage
d Late inflammation (48 h)
Collagen
Fibroblast
e Proliferation (72 h)
f Remodelling (weeks to months)

The phases of cutaneous wound healing

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The Visceral Impact of the Wound

While nurses are adept at assessment of wounds for the purposes of documentation and evaluation, the emotional and/or visceral impact of the wound on the nurse is not included as relevant clinical data. As well, nurses are not trained or taught how to deal with their own emotions and reactions as they carry out these physical, task-oriented interventions. " In many ways, nurses operate in a social vacuum because as neophytes, they are often naïve or ill-informed (at best) about the work they are expected to do and how they can behave. Little, if anything, in their lives prepares them for what they are required to do for others as basic nursing (body) care" (Lawler, 1991, p. 129)

Laurene , acute care:

I guess initially you are going in and thinking this is a pressure ulcer, this is a gallbladder incision, this is what I need to do. At first, as a [new] nurse, you start out with the task, and then you start learning, ' okay this is so and so's father and[he's] this really nice gentleman that has this horrific wound. Then you start to deal with the whole picture more. I didn't do that at first because it was a narrow focus at the start, because it was just overwhelming as a new graduate. Now I think they teach [nursing students] in school to treat the patient holistically you know, but actually it is hard to do that at first—at least until you get some experience. It's just a lot to learn to deal with the physical things or what to do with different dressings..."

Laurene describes her feelings as a new nurse, needing knowledge "under her belt" prior to being able to open up to the complexity of the whole person. This assertion is supported by Benner's view that the novice and advanced beginner " can take in little of the situation: it is too new, too strange, and besides they have to concentrate on remembering the rules they have been taught" (Benner, 1984, p. 24).

The nurses in this study described their experiences of changing a dressing in ways that included sensory and emotional perspectives of "the wound itself". The describing of the wound was a recurring theme, as the nurses engaged in recollections of experiences from early in their careers to the present day.

Gabrielle, acute care:

The first wound I ever saw was a decubitus ulcer and everything was exposed. I didn't even know what had happened and what I was seeing…It had an odour to it and I just remember thinking, " Oh my God, this is horrible!"

Deb, long term care:

There's one that really stands out right now. When I'm walking into the room the biggest thing that stands out is that the resident is so self-conscious. She watches to see your reaction.

It's a kind of a shoulder dressing where she has had a cancerous tumour removed, so it goes very deep and is very foul-smelling. It has a lot of drainage and she just stares at you the whole time to see your reaction. She herself will hold a towel to her face because of the smell, but she just stares at your face to see if you look startled or shocked.

Hazel, Acute care:

[talking about a patient with a long-standing wound]: *she couldn't go out because she thought that her legs smelled and it would put people off, so of course, you know, coming into the hospital, people were used to all the smells…so she would come to us and we wouldn't be bothered by it.*

There is an emotional potency to the evocation of odour. Hanna, the young nurse in Ondaatje's *The English Patient* (1992), sits beside the burned man she is caring for.

" She lifts both his hands to her face and smelled them—the odour of sickness still in them". She then begins to read to him but drifts into a reverie: "Whenever her father was alone with a dog in the house he would lean over and smell the skin at the base of its paw. This, he would say, as if coming away from a brandy snifter, is the greatest smell in the world! A bouquet! Great rumours of travel! She would pretend disgust, but the dog's paw *was* a wonder: the smell of it never suggested dirt. It's a cathedral! her father had said, so-and-so's garden, that field of grasses, a walk through cyclamen—a concentration of hints of all the paths the animal had taken during the day" (p. 8).

Elizabeth, one of the nurses from long term care, vividly remembers a patient whose malodourous wound she dressed as a consolidation student on a palliative care unit. Her story, like memories Hanna recalls of her father, connected to the smell of the earth on a dog's paws, evokes the emotion of a woman aware of her impending death, her unmeasureable sadness and the resonance of that relationship with a young nurse.

Elizabeth, long term care:

I remember a lady I had that was mid 40s, you know, had kids and she had a large ulcer on her buttocks that took up her one buttock. And here I am with kling, packing that wound, I mean that was when I was in training, but that's one…(sighs). I will never forget her, never forget her...

She got diagnosed with cancer and it was very sudden, everything seemed to take over. This was during my consolidation on the palliative care unit. I remember over the 7 weeks she deteriorated so much. Then you have to deal with the pain and watch her friends coming in and seeing her, I think, they always got very emotional, and she'd get emotional too, of course.

I remember when her daughter came from Europe and she hadn't seen her for about six months. That day she was balling her eyes out, we were all balling our eyes out. The daughter, everybody was upset…Then she came to a point where she decided to make sure her Will was done when her daughter was there, and that was emotional...

Yes, we tended the wound every day but I think we spent all this extra time with her too and you know,,there was odour, it was an odorous smell. That was a bad wound…She'd often be in a lot of discomfort and she had pain…often she had company and we'd come back to do the dressing.

Often it would be at 6am you'd go in to do the dressing. That's when she would open up-- she kind of hid it when other people were there, but then during that 6:00 in the morning when you're doing her dressing, that was when she would talk about everything. She would say how, what was going to happen when she was *gone, and about her kids ... Once her daughter arrived, [the patient] she passed away about three weeks later. It was in the time from my consolidation to my graduation, she had passed away..., but ... yeah.(sighs) That's just something I'll never forget.*

The wound was often described by the nurses in this study in terms of its odour and the impact of the smell of the wound on the nurse and on the patient. It is this emotional response to wound odour that seemed to prompt the nurses to speak more of the experience. They expressed how the odour of the wound made them feel, how it made the patient feel, or how they imagined the patient felt about the odour of the wound.

Marcel Proust, in *Swann's Way*, (1922, 2002) wrote of the impact of smelling linden tea and Madeleine biscuits as the gateway to his memories of his childhood visits to his aunt's home in the French country-side. This recollection of odour provides a strong connection between past experience and response to a new experience where the odour prompts emotional memory (Herz, 2004; Herz, 1998)

Margaret, acute care:

I try not to let anybody else know around me, that's why I breathe through my mouth. But actually you know, you keep that compassion in your mind while you are there doing something [the dressing change]. So I very, very seldom try to act shocked. That's probably my goal.

Laurene, acute care:

The most important thing is not to let the patient know that the smell is making you feel uncomfortable because I'm sure they know that it smells not particularly nice and it's going to put people off. I think the most important thing is to put your patient at ease. I mean, a dressing is part of your nursing care, so you can't say, " well, I'm not going to do it today because of the smell". You just get on it and do it, it's part of your patient's care.

Interviewer: And how do you deal with it? With the experience?

Laurene: *I just think of it as part of the job. You know, why [the patient] has come in, they need to have something done, you're just going to do it, you're not going to get all squeamish about it.*

The response of these nurses to the wound odour demonstrate sensitivity towards the meaning of the wound for the patient. As Dr. Bernard Lown describes in *The lost art of healing*: *Practicing compassion in medicine* (1999) the care-giver who is focused on the mechanics of diagnosis and treatment loses sight of the impact of the illness (and how this may be manifested) on the patient. Attending to the wound but being simultaneously involved in the whole-ness of the individual, demonstrates the nurse's ability to be in touch with both the lived body (the private, lived reality of the person) and object body (the public functional aspects of the body). This subconscious act enables nurses such as Laurene and Margaret to mediate the dichotomy inherent in this duality (Gadow, 1980).

· The nursing culture supports the use of the technical skill-set objectives which are amenable to numeric measurement to effectively evaluate students and new graduates. It is an approach that provides the novice nurse with a framework for practice which can be less threatening than the chaotic messiness that is the reality of day-to-day patient care.

> This material deals with technological aspects of care which stem from the application of new equipment and new procedures in medicine and better understanding of physiology and biochemistry. It is neither material which concerns 'dirt' nor material which reflects the existential aspects of embodiment, about which nurses are concerned in their daily practice. (Lawler, 1991, p. 38).

Margaret , acute care:

"...from a student perspective, you can teach students...when they have the one- on-one care with the patient, then that would increase their knowledge base. But not all patients get students, and not all students have an interest in that kind of thing, you know, I don't see that. They[the students] aren't necessarily looking at the patient from a holistic standpoint, what are we doing to prevent this from happening. They look, 'Oh, the patient has a wound, what do I need to do to change this?'...or, ' how do I give a shot, how do I put a Foley [catheter] in, how do I do a dressing change?'. Not, ' how am I going to prevent breakdown', or 'what's the best way', or 'what's consistency in care'. It's 'how do I do a dressing, show me, do it, and I'll do it'. It's not looking at the whole picture."

I would say the first six months I was in nursing, I went home crying every night. I stopped being a task-oriented nurse and become a holistic nurse…I think it was when I had to start dealing with family issues, the family dynamics and the patient's pain level. It wasn't just the case of, as a student, I would walk in and do the wound and walk out. Now I had to walk into a complication, is the bed in the best situation, are we turning him more often, so [I] had to start looking at the patient from a more 'this is a whole human being and is not just a patient'

Margaret recognized that she was able to connect with the patient through the experience of providing care. The wound itself was a vehicle of her understanding of the patient's experience. Her response, as the embodied nurse, reflects Benner's view that " each stage of skill acquisition leads to a more differentiated world of practice, and enhanced capacities for meeting and engaging in helping relationships" (Benner, 2000, p. 8).

Joanne, a new graduate, with a year of nursing in acute care:

"I pretend that it's not really that gross, but I guess in some ways I find it interesting. So you know, in my head, I'm thinking it is gross but I am also very interested, like "Wow, look at that!" I guess it's probably that I'm still learning that I think it is interesting more than it's disgusting."

Benner's description of the stages of nursing practice in her seminal book, *From Novice to Expert* (1984), mirrors the experiences of nurses in this study. Joanne, the novice nurse explores the apparent dichotomy within her own clinical nursing practice, of being simultaneously repelled and attracted to wounds and wound care and speculates that her interest in wounds is related to " still learning".

However, many of the more seasoned nurses who participated in this study responded as Margaret did, describing the holistic nature of the relationship with patients as satisfying and indeed, brings them to a level of understanding the needs and issues of the individual patient in ways that enhance the direct care they provide.

Hazel, acute care:

"[With more experience], I was more organized and had more time to think about the other issues, like what can I do better for this wound or does this person need sedation. I could talk about other things and reassure [the patient] while actually doing [the dressing]… I guess it's easier when you get more experience under your belt and you know how to treat the different wounds. Then you can deal with the other aspects—social, emotional".

Recognition of the holistic nature of caring for patients was expressed by many of the nurses in this study. As Benner points out, it is the more experienced nurse who is able to integrate the various issues relevant to the patient at that particular time and place and be able to step into the relationship where it will be meaningful for the patient. " This holistic understanding improves the proficient nurse's decision making; it becomes less labored because the nurse now has a perspective on which of the many existing attributes and aspects present are the important ones" (Benner, 1984, p. 29).

The Reality of the Wound

Saturn eating his offspring, Goya, 1810, Prado Museum

This dark and terrible painting, "Saturn eating his offspring" by Goya is based on the Greek myth of Kronos (Saturn) who regularly devoured his children to ensure none of them would overthrow him. Many of Goya's paintings reflect the horror of war during the occupation of Madrid by Napoleon's army, from 1808 to 1814.

This particular painting, capturing Saturn in the act of devouring his child, visually and emotionally shocks the viewer. Nevertheless, at the same time, the painting itself can be admired for its composition, for the use of light and dark in revealing the terrible mouth and anguished eyes of Kronos. In the same way, the emotional revulsion of visualizing a wound and the recognition of the flesh eaten away from the body, destroying the integrity not only of tissue but of the individual him/herself is countered by the nurse's intellectual distancing required to assess and plan for appropriate care.

Natalie, community care:

" I'll never forget this woman. She had a crater in her pelvic area [from the cancer]and it was horrific. It was just terrible. I think she was very uncomfortable with the odour and the appearance of it. I remember particularly trying not to show emotion or dismay."

The wound itself is a thing that defies humanity, as it is an expression of failure — of the body, the system and the caregiver. A family member will ask, "How did this ever happen?", as if the wound might have been prevented. In some situations, the wound might indeed have been prevented, but in many instances, pressure ulcers develop from factors that are difficult to control or mitigate.

Thus, the breakdown of skin is an insidious assault on the body, with both external and internal issues affecting both cause and outcome. Although pressure plays a major role, the individual's own situation regarding nutrition, sensation, disease process, infection, incontinence, etc. have a great impact on the development and progress of the wound. While the wounds of combat and accidents are precipitous occurrences, visibly demanding action and involvement, chronic wounds, notably pressure ulcers, hide from view as they develop over time. It is as if the body itself is a silent but duplicitous participant in the process.

Holly, community care:

I think the worst ones I have seen, apart from the gentleman that had the enormous hole in his chest, are a lot of amputations that break down, particularly above knee. They seem to break down and look very horrific, you know, they look like a big gaping mouth.

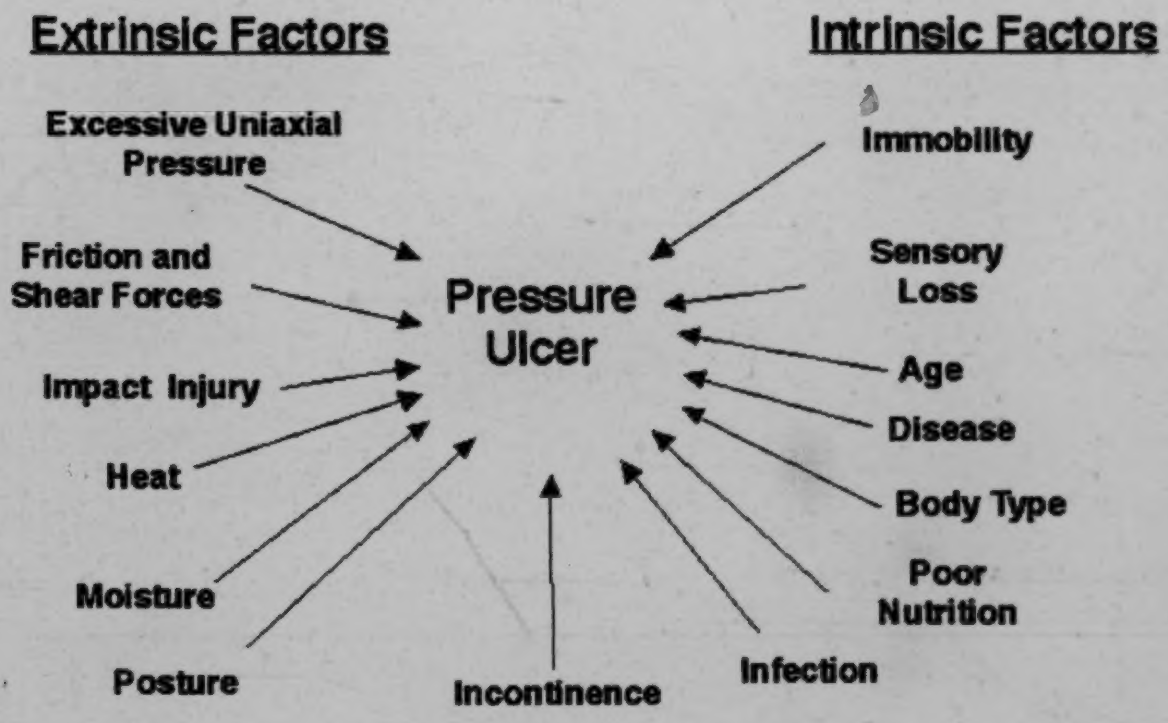
The intrinsic and extrinsic factors are illustrated in Figure 4.1 to demonstrate the multiple issues impacting on wound development. A number of these factors, which can be challenging to address, often affect the patient simultaneously and may all be crucial to the healing potential of the wound. Thus, nurses need to be aware of these factors and be prepared to mobilize a plan of action to address all of these issues in order to improve or heal the wound. As mentioned in an earlier section of this chapter, the wound is not simply, "a dressing change", but rather a host of complex issues which the nurse takes in as he/she assesses the wound.

Pam , community care:

"When I first enter in a home…I sit down and make them comfortable with me… I question them on their general medical history so I have an idea of whether we're dealing with someone who has diabetes, congestive heart failure… I question them on their smoking history, drinking history, so you get more of an idea what kind of lifestyle they've led that may lead to hidden problems that could affect wound healing…When I've got a whole physical picture of the client, that's when I move to the wound itself. And not until then.

The wound does not stand alone as a singular element of the nurse's understanding of the patient's needs. In fact it is quite the opposite. The complexity of the elements surrounding the wound, from the physiological and physical intrinsic factors to those aspects that are outside the body, impact on the wound's potential for healing. As Pam describes, the nurse must pause and sift through all these elements prior to dealing with the concern of the dressing change itself (see Figure 4.2).

Figure 4.2: Illustration of the extrinsic and intrinsic factors affecting the development and healing potential of pressure ulcers.


Extrinsic Factors
Intrinsic Factors
Excessive Uniaxial Pressure
Friction and Shear Forces
Impact Injury
Heat
Moisture
Posture
Incontinence
Infection
Poor Nutrition
Body Type
Disease
Age
Sensory Loss
Immobility
Pressure Ulcer

Seeing the Wound

What nurses see and deal with in the context of providing wound care is not often experienced by others. Wound care is an intimate "behind the screens" activity of the nurse and patient. However in order to understand what it is that the nurses speak of and experience as they describe their world of changing a dressing, it is important for the reader to see the visceral reality of wounds. These images are taken from my own practice but reflect the typical wounds seen by any nurse providing wound care across the continuum.

Patients or their substitute decision-makers have given written permission for use of these phototgraphs. Patient initials and descriptions of situations have been altered to ensure confidentiality is protected.

Nurses with whom I have spoken, in this study and elsewhere in my clinical practice, have remarked on their own silence regarding descriptions of what they do when confronted with wounds. Over and over again, nurses express a reluctance to "burden" others with the knowledge of the reality of wounds, which can be so disfiguring, have such rank odour and be so visceral. It is my belief that the nurses protect themselves and others by keeping silent, by seeing but not describing in detail what they see. One of my colleagues, not in this study, but a nurse with whom I frequently work, spoke of her reluctance to discuss wound care with other nurses. " I can't bring myself to put them in a position of listening and visualizing what I've seen or done. It's not fair to them. They have their own patients and their own thoughts to deal with. I don't have to add to their day by grossing them out".

The following poem reflects the experience of a nurse caring for a patient with a large surgical wound. In her words, we see and feel both the horror and the compassion of the nurse as she changes the dressing.

Dehiscence

You have come unstitched.

Holes appear on your threadbare abdomen.
Tunnels develop and connect bowel, liver, pancreas.
Enzymes ooze out and digest your skin,
no matter how hard we try to stem the flow.
Mounds of dressings,
miles of tape—a jury-rigged system to
hold together our mistakes.
The stench is overwhelming, ever present,
reminding everyone, but especially you,
that you have come undone.

Since I cannot bear your suffering,
since the truth is too horrible to grasp,
since I can offier you nothing else,
I clean you up,
I wash your face,
brush your teeth,
comb your hair,
turn you gently on your side,
push soiled linens away,
roll clean sheets under you,
remove layers and layers of damp, disgusting dressings

and replace them with new dressings and tape.

Since I am helpless in the face of your tragedy,
I give you the certainty and calmness of my motions,
the competence and comfort of my touch
as I smooth the top sheet over my work.
Done.
For a few pristine moments, we allow ourselves
to be caught in the illusion of your wholeness.

Amy Haddad, in *Between the Heartbeats, 1995, p. 86*

Photo 1: sacral ulcer, Stage II

Mrs. L. is an 83 year old woman who has been living at home with her 87 year old husband. She had a stroke six months ago that left her with limited mobility. She has had increasing difficulties managing to get up to the bathroom at home. She was admitted to hospital with a urinary tract infection and dehydration.

The excoriated, ragged edges of the skin are further broken down by the burning of acidic urine and feces. Incontinence creates raw skin. The dark purplish colour of the underlying tissue is evidence of trauma to the capillaries as the supply of blood is occluded by the pressure of the body on its flesh, as the patient lies immobile. The yellow spot is an area of fibrinous slough, which develops as a stringy layer of tissue that prevents granulation from occurring.

The raw, exposed tissue is full of nerve endings. This area is exquisitely painful to the patient. The excoriated areas burn when touched by urine or fecal matter. Any dressing will be difficult to adhere because the tissue is so fragile. The area to be covered by a dressing (if possible) is large and complicated by its location. It would be impractical to apply a dressing that blocks the rectum if the bowel is normally functional.

The nurse's response to the wound and to the dressing is focussed on the practical, in-the-moment reality of providing the technical, skilled care of a dressing change. However, at the same time, there is a personal, emotional response to visualizing the wound. This ability to simultaneously objectify and personalize the wound demonstrates a collusion of Merleau-Ponty's (1962) principle of embodiment and Sherwin's (1998) notion of clinical phronesis which exemplifies the ability of the nurse to enter with his/her whole being into the relationship with the wound and with the patient.

Susan , community care:

I'll never forget the day I walked into a lady's home and all I'd ever done before for her was change her[IV site] dressing. And her breast tumor had started to fungate. I remember she took that dressing off and I don't know what my face looked like, but she said, are you all right? I just wanted to cry. I just saw this awful mass coming out of her body. I don't know, didn't know other than to feel so terrible for her..yet at the same time just thinking how to deal with the odour, the pain...

Yeah, those are awful. [Another time] I'll never forget, when I worked in the hospital, a fellow had cancer in the face and his nose was literally gone and he had a great big huge concave in his face and you walked into the room and it just stunk. I often think of him now when I know more about wound care but the one thing we did right was we gave him a private room, that's one thing we did right. But we use normal saline wet to dry. What was that going to do for the odor? That poor man! Yeah.

Photo 2: Bony prominence over spine (mid-back)

Mr. G is a 78 year old gentleman with Alzheimer's Disease. He has been living in a long term care setting for the past five years. Lately he has been disinterested in food and has gone into what the LTC Director of Care has called a "slow decline". He was admitted to hospital for insertion of a feeding tube to address the nutritional issues. Mr. G. spends most of his time either in a geriatric chair or in bed.

The thin skin covering his back has been further depleted by Mr. G's poor nutritional status and dehydration on admission to hospital. The wound base is covered by thick yellow fibrinous tissue that limits any visualization of what might lie beneath. The reddened peri-wound skin has minimal sensation and appears to be preparing to break down even further. The bony spine is evident just below the skin.

While dressings will provide some protection to the healing tissue and encourage autolytic debridement to occur, relieving the pressure will be the most useful treatment (other than improving his nutritional status) to begin to heal this wound. Thus a pressure relief surface for both bed and wheelchair/geriatric chair were recommended. As well, Mr. G. was encouraged to reposition every two hours, with assistance from the physiotherapist and occupational therapist who provided foam wedges to help keep him repositioned.

Gabrielle, acute care:

I see that it's not just something that happens overnight. I used to think, oh my God, how did this happen, you know, it must have just happened over night. But as you learn, that's when you start to realize you know what you can do to prevent it.

…Now when I see a wound I think of so many other things around it, around the whole issue of wound care, like nutrition, what else is going on rather than just the wound itself. The whole healing process seems to jump out at me. I'm looking at not just the wound.

This ability to see both the wound itself and the factors impinging on the wound healing, as described by Gabrielle, reflect the nurse's approach to holistic rather than instrumental care. Nursing assessment tends to move from the particular to the general as the nurse seeks to understand all the factors affecting the patient, from a biopsychosocial perspective. This approach, widely accepted in nursing, provides a dynamic intertwining of physical condition, psychological states and environmental circumstances (Kleinman, 1988)

Photo 3: Femoral line infection

Mr. M is a 34 year old gentleman who developed a femoral line infection while in hospital. The wound is on the anterior inner aspect of the right thigh. His right arm (with dressing) can be seen and the large abdomen overhangs the thighs. The yellow area of the wound is composed of fibrinous slough. There is a gray area towards the lower edge of the yellow slough that may be evidence of deeper infection. The red/dark tissue covering the right third of the wound is raw and excoriated tissue. The irregular margins and reddened area to the left are granulating tissue.

This infected wound was very painful for the patient, as well as being in an embarrassing location, close to the genital area. Initially, twice daily dressings were required, due to the drainage. By the time this photo was taken, dressings were being changed every two days.

The intimacy and potential embarrassment of the patient is not lost on the nurse. Nurses must negotiate the cultural and status-bound aspects of social relations when they touch patients and some of that touch necessarily involves handling parts of the body which are normally only touched in sexual encounters (Lawler, 1991).

Holly, community nurse:

It's very intimate. You know, people are exposing an area on their body that may not be seen otherwise. So there's a certain amount of privilege, if you like, and that may sound odd, but I find that patients who are dying, the first thing that comes to me is, 'It's been a privilege to look after you'.

Photo 4: sacral pressure ulcer and friction/shear wound.

Mrs. A. is an 89 year old woman from a Long Term Care facility, admitted to hospital with a G.I. bleed. She had a recent hip replacement which had healed well, but the sacral ulcer had developed while in hospital for that surgery and was not yet resolved. Mrs. A used a wheelchair and at the LTC facility was accustomed to transferring from bed to chair with minimal assistance. However, because of her diminished strength, she was less able to transfer and had developed an excoriated skin tear on the right buttock, related to the friction and shear from transfers from bed to wheelchair and back.

Deb, long term care:

A lot of it's emotional for the patient, or not even emotional, but you just have to kind of anticipate how they're going to react. Because a lot of them do find it upsetting, even if it is a wheelchair scrape, all of a sudden they think, ' oh no, its going to get infected and I'm going to need antibiotics'. So you have to deal with the patient's feelings, more than just the physical wound.

I think especially in long term care one of the important things is to remember [the patient] as a person and why you're doing the dressing and how they feel. Anybody can physically be taught anything manually what to do, like how to do a dressing. But I think in long term you have to realize this person may inside be dealing with some issue while you're changing this dressing.

Elizabeth , long term care:

... I always try to think, okay what am I going to tell the resident to give them reassurance that just because it's a different person today everything's going to be okay. I usually walk through those step by step, exactly what I'm doing... and I'll tell them when I'm packing it, you know, I'm going to pack your wound so you

may feel me poking it…I try to make it as simple for them as possible, but let them know what's going on because sometimes they feel kind of isolated you know, especially if you're doing a coccyx wound. They can't see what's going on then. " This understanding of the patient's real life world with all of the events, consequences and relationships by a phronetic clinician is a form of embodied realism." (Chan, 2005) The nurse's ability to recognize the fears and concerns of the patient, without the need to explicitly elicit this information demonstrates not only a level of clinical expertise as described by Benner (1984) but as well the sentient understanding of the experience, the embodied nature of the act of changing the dressing. Elizabeth relates her need to talk with the resident as she provides wound care as a way of responding to the *isolation* of the patient with the wound. There is an unspoken recognition of the essential alone-ness of the patient and her wound as Elizabeth speaks to the patient as she changes the dressing.

Photo 5. Palliative wounds.

Frances, long term care:

Sometimes you can do stuff to a wound but whether that wound heals or not, sometimes it depends more on the person than it is on what I do. I know that some wounds don't heal and you accept that. But then, sometimes you think, "what did I miss, how could this happen on my watch". Like the patient who came back post hip fracture and developed a bad ulcer on the fracture site… She came back with these staples in and you know, look what happened! We tried to keep her off that hip and what did we do? I think the staff felt guilty, although it probably was an osteomyletis underneath everything. Sometimes you still worry that you should have done more.

" We are all fallible human beings who know so little about the human body. The public is paying us to be certain, to fix everything, to have all the answers. Understandably that's what they want. We are all human beings doing the best we can, but they don't care, they just want their loved one better" (Shalof, 2004, p. 256).

This expectation of the nurses themselves, to nourish, heal and above all, protect the patient is rooted in the role of the nurse. Guilt or uncertainty at 'not having done everything' pervades the thoughts of nurses and reinforces the on-going presence of this undercurrent of desire to do the right thing for patients. In Frances' voice, one can hear the worry and anxiety as she questions her abilities, her competence as a nurse. The wound evokes these feelings because it is visible; it shows the nurse how she may be fallible (for example, the developing infection).

She should have *seen* the problem, despite the fact that it may not be visible to the naked eye.

Nightingale's assertions in the classic, *Notes on Nursing,* are thus still entrenched in the culture of nursing. " The reparative process which Nature has instituted and which we call disease has been hindered by some want of knowledge or attention in one or in all of these things, and pain, suffering or interruption of the whole process sets in. If a patient is cold, if a patient is feverish, if a patient is faint, if he is sick after taking food, if he has a bed-sore, it is generally the fault not of the disease, but of the nursing" (Nightingale, 1859/1945, p. 6).

Awareness of the Nurse

Nurses who provide wound care see all the horrors of the body as it begins to decay. But their purposefulness in approaching both the wound and the patient is as Walt Whitman articulated in this poem, "The Wound Dresser", which is reproduced in part below.

Walt Whitman, the American poet (1819–1892) was a wound dresser during the Civil War and this experience profoundly affected him. Within many of his poems, Whitman was able to transcend the horrors of war and find affirmation and joy in the physical beauty of nature. However, in the poem, "The Wound Dresser", Whitman speaks eloquently of the unadorned tragedy of caring for wounded and dying young soldiers. He carries out his tasks as wound dresser with skill and patience, moving from one bedside to the next, observing the distress of destroyed young lives. Yet he continues methodically to provide care. Only momentarily, at the final verse, his own emotional anguish is expressed: "deep in my breast, a fire, a burning flame".

Laurene, acute care:

(speaking of coming to the dressing change):

It's the sort of thing you're going to do…you talk to the patient a little bit, try and get to know them a little bit and ask them about what I'm going to do…and hopefully gain a bit of trust on their part. Then we can do whatever we've got to do. I think you can't just go in there and say " I'm going to do this" and then go at it gung ho.

Pam , community care:

I've never been shocked by a wound, I mean and I have seem some really, really large wounds, particularly chest wounds, they're the ones that can separate. Now sometimes it gets to me if it's a dehisced wound.

Interviewer: So how do you deal with that? What do you do?

Pam: *Hold my breath most of the time. [laughs] But [for example], once I had one gentleman one time and he had four vag packs in this chest wound. You could see, it was literally that width [holding hands a foot apart] and you could literally see the chest wall and he had pockets all around of pus… The smell when you were taking out the packing, well I had to hold my breath and I couldn't lean over him to do it, I had to actually stay slightly away. But when I think of it and how bad it was for me, I had to think of how bad it was for him.*

From **The Wound Dresser** by Walt Whitman

But in silence, in dreams' projections,
While the world of gain and appearance and mirth goes on,
So soon what is over forgotten, and waves wash the imprints off the sand,
With hinged knees returning I enter the doors (while for you up there,
Whoever you are, follow without noise and be of strong heart).

* * *

Bearing the bandages, water and sponge,
Straight and swift to my wounded I go,
Where they lie on the ground after the battle brought in,
Where their priceless blood reddens the grass, the ground,
Or to the rows of the hospital tent, or under the roof'd hospital,
To the long rows of cots up and down each side I return,
To each and all one after another I draw near, not one do I miss,
An attendant follows holding a tray, he carries a refuse pail,
Soon to be fill'd with clotted rags and blood, emptied, and fill'd again.

* * *

I onward go, I stop,
With hinged knees and steady hand to dress wounds,
I am firm with each, the pangs are sharp yet unavoidable,
One turns to me his appealing eyes—poor boy! I never knew you,
Yet I think I could not refuse this moment to die for you, if that would save
you.

* * *

On, on I go, (open doors of time! open hospital doors!)
The crush'd head I dress (poor crazed hand tear not the bandage away),
The neck of the cavalry-man with the bullet through and through I examine,
Hard the breathing rattles, quite glazed already the eye,
yet life struggles hard
(Come sweet death! be persuaded O beautiful death!
In mercy come quickly).

From the stump of the arm, the amputated hand,
I undo the clotted lint, remove the slough,
wash off the matter and blood,
Back on his pillow the soldier bends with curv'd neck and side-falling head,
His eyes are closed, his face is pale, he dares not look on the bloody stump,
And has not yet look'd on it.

I dress a wound in the side, deep, deep,
But a day or two more, for see the frame all wasted and sinking,
And the yellow-blue countenance see.
I dress the perforated shoulder, the foot with the bullet-wound,
Cleanse the one with a gnawing and putrid gangrene,
so sickening, so offensive,
While the attendant stands behind aside me holding the tray and pail.

I am faithful, I do not give out,
The fractur'd thigh, the knee, the wound in the abdomen,
These and more I dress with impassive hand
(yet deep in my breast a fire, a burning flame).

* * *

Photo: Author (permission obtained)

Laurene, acute care:

I have to be careful with my facial expressions. [We had a patient who had an allergic reaction to a medication]. The skin on her legs just sloughed off and it was like raw hamburger!... I was helping the doctor that was debriding the skin off, and the patient said, "Are you alright?", because I didn't even realize that my mouth was hanging open. I was so embarrassed, I apologized and I just felt terrible that she could tell I was horrified.

This awareness of the patient's world of the wound provides the context for the nurse's response to the wound. As Laurene describes, she was unaware of her reaction until the patient pointed it out. However once she realized how her reaction might have affected the patient's view of her body, Laurene was able to rectify the situation by acknowledging both her own human-ness and its impact on the patient.

Gastmans (1998) review of Peplau's work, notably "*The Therapeutic Relationship*" (1952) describes this approach: " Nurses cannot perform …in a context-free or value-neutral way; on the contrary, the impression that nurses attempt to acquire of the patient's overall medical and existential situation can only come from an attitude of involvement and openness to the total life-world of the patient" (Gastmans, 1998, p1314).

The focus of this chapter has been on the nurse's experience of the wound itself. The reality of the visceral nature of the wound, the pain, the odour, the difficulty managing dressings, are troubling to the nurses who must plunge deeply, both literally and figuratively, into the wound as they care for their patients. There are few nursing tasks that are more intimate that those involved in wound care.

There is a need to cover and protect within the intimate physicality of the act of changing a dressing. The nurses expressed the wish to protect their patients from visualizing their loss of body integrity, hence the attention to neutral facial expressions and focus on healing potential .

In the next chapter, the temporal, spatial and relational aspects of the world beyond the wound will be discussed.

Chapter Five: the World Beyond:

Environment, Time and Relationships.

Photo: Author (permission obtained)

The Nursing World Beyond the Wound

I open the door and enter into the workplace. The hall is long and cluttered with gurneys, carts and wheelchairs. There are patients sitting in Geri chairs and some lying on gurneys, waiting to go for treatment or tests. Nurses in colourful uniforms, doctors and other health care workers (physiotherapist, dietician, aides) walk along and disappear into patient rooms.

There is no way to disguise the scent of sickness in the hospital, despite the use of deodorizers and air fresheners. As I walk down the long hallway of our unit, it is easy to locate the gastro-intestinal bleed by its distinctive odour. The stench of a gangrenous wound or a patient with a pseudomonas infection, with its characteristic cloying, sweet smell are part of my daily world.

The walls are a dusty pink and the tiles on the floor have similar tones of pink and pale gray. This is an old building and little has been done to up-grade or modernize this area since we will be moving to a newer building soon. Of course, we have been hearing this message for as long as any of us can remember. Certainly, I was told, "Don't get too comfortable with this space, we'll be moving soon" when I was hired twelve years ago. It's a running joke here on this Medicine unit, and we use that excuse to explain why the equipment we have seems so antiquated (the bedpan flushers for example), why the patient rooms are so cramped.

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The bedside curtains hang off the track, as the curtain hooks that have fallen off have never been replaced. The curtains look like dropped hems on skirts that are out of style and no longer fit properly. We use enormous safety pins to hold them together to provide some semblance of privacy for patients. Dressing changes, behind these flimsy 'walls' is claustrophobic and sweaty as we are jammed in between beds, curtains, pumps on wheels, bedside tables and all the other paraphernalia of medical care. I am forever apologizing for my elbow, my bottom, my voice, intruding on the 'space' of the patient in the next bed.

As van Manen (1997 b) asserts, the world encompasses space, time and relationships and attempts to separate each of these aspects for nurses can be difficult and threaten to lose the true meaning of the experience, which by its very nature is imprecise, blurred. In addition, the language of the nursing workplace in nursing culture and literature describes the impact of workload, shift work, injuries or models of professional practice or abstract concepts such as empowerment which preclude the richness and depth of meaning as nurses move through the work day. There is little within the literature that refers directly to the experiences of nurses living through the day-to-day temporal and spatial environments of their work.

Nurses in this study were often describing their experiences of changing a dressing in a setting that was removed from their usual workplace. That in itself required recollection of the nurses's world that gave a descriptive vista of highlights, flavourful memories and important moments revealing those aspects that had meaning for the nurse herself at that particular time.

For example, Pam, a community nurse, recollected how the first visit to a patient at home occurred:

Pam, community care:

... I'll call when I'm on my way, just to remind them that I'm coming, because I always make sure they know exactly what's happening. Then when I arrive at the door, I'll say 'Hi, I'm Pam, and I'm going to do this dressing...

In the community we don't have the luxury of sterilized dressing trays, so we have a routine with boiling instruments in a pot...so I have a lot to say to that patient on the first visit. Not only am I coming as a new person, a stranger, I have to build up some kind of rapport with them, I have to explain the routine and if I can I'll even say[to them], ' Can you think of some pot with a lid for future visits?'. I usually bring in forceps and the packing and whatever else we need to do the dressing. .. I explain that, I always take my time and say it in layman's terms.

Pam describes how her interaction with the patient at the first visit is imbued with the sense of the clinical phronesis, or the wisdom of practice. As described by Schultz and Carnavale (1996), this approach to the patient's needs comes from a perspective that is wholly attuned to the patient. It is a practice that is open, attentive and accepting. While this approach would seem to push up against the realities of the clinical world of time, space and relational transactions, it appears to relax the barriers as the nurse relates to the here-and-now of being present with the patient.

While the nurses in acute and long term care do not speak directly of the physical environment in relation to their experience of changing a dressing, their words describe how they feel situated in the landscape of the workplace. As van Manen points out, the notion of space (lived space) is not confined to the physical, mathematically measureable space but is constructed in ways that evoke the "fundamental meaning dimensions of lived life" (van Manen, 1997 b, p. 103*)*.

Frances, long term care:

I love the give and take of back and forth with the residents. I guess I just really do look forward to going to work; every day is a different day and some days things are going to be better and some days they aren't but we'll make it better, you have that challenge. There's always been a resident if you're having a really bad day, you can sneak in and spend 10 minutes and come out feeling like a better person, that's what I find in long term care, there's always that.

Frances' description of the reciprocity within her work environment is not only the reciprocity of her relationship with patients, it is the up and down nature of "good days and bad days", which she does not need to itemize for the reader to understand what she means. The image created by Frances' description of finding replenishment from a ten minute hiatus with one of the residents ("sneak in and spend 10 minutes") is evocative of the opportunity to receive the gift of renewal from a patient. Seeking out those whom the nurse herself recognizes as being able to re-energize, provides her with a place to go to restore balance and continue working.

Merleau-Ponty (1962) describes the body as it inhabits space and time as an experience that does not require explicit meaning, rather it engages the world in a multi-dimensional, fluid manner:

> When I move about my house, I know without thinking about it that walking towards the bathroom means passing near the bedroom, that looking at the window means having the fireplace on my left. ... In the same way, there is a 'world of thoughts', or a sediment left by our

> mental processes, which enables us to rely on our concepts and acquired judgements as we might on things there in front of us… without there being a need for us to resynthesize them. In this way there can be for us a sort of mental panorama, with its clear-cut and vague areas…
>
> (p. 149-150)

Pam, describes the experience of visiting a patient who was discharged from hospital following a cholycystectomy that paints a vivid picture of the patient's world:

Pam, community care:

In community, part of the agenda to get the family involved in changing the dressing, but they couldn't start to even think about that for awhile because he was in such pain. [As the nurse] you see the family and the stress that all this caused. This man was not the main breadwinner, but he was home with this terrible wound. I remember it was through Christmas too, it was snowing. Four months we were in there, and he healed. He did very well, but it was very traumatic, the very first couple of weeks. [Initially]I found I had to take a deep breath and try to keep him calm, it was very upsetting for him. And depressing too.

The wound for the nurse is not isolated from the rest of the patient. Nurses do not talk about the wound as standing alone. The wound fits inside nursing and cannot be cut off from everything else the nurses do, or from the other parts of the world within which the nurse works.

Times are Changing, Patient Care Practices Evolve

In this study, nurses from three care settings were interviewed: acute, long term and community care. I was interested in seeing whether there were differences in how the nurses from the three different settings talked about their experiences of doing dressing changes. How nurses related with physicians, what time constraints existed and how the work-place (staff mix, environment) was configured all had potential impact on the nurse's experience of changing dressings.

Much of nursing is rooted in the culture of the past, particularly in military design. Hierarchical relationships, regimented schedules and rules of conduct still form the framework for much of the nursing environment. Wound care has been a place where physician and nurse have had a traditionally paternalistic pattern. However, the past decade has seen a substantial shift in how the nurse/doctor relationship is expressed, as well as the ways in which nurses implement their roles.

Wound care and dressing changes have always been a shared role for doctors and nurses. Historically, the role of the physician was to write the order to dress the wound and over-see the wound's progress. The role of the nurse included making dressings (primarily cutting squares of gauze and decanting tincture of Iodine into bottles) and physically changing the dressing (cleansing, irrigating, packing and wrapping the wound) as ordered by the physician. In *From the voices of nurses, an oral history of Newfoundland nurses who graduated prior to 1950*, the nurses recount stories of their experiences:

> *" At ten o'clock, you had your nourishment break. By then you should have had all your patients done with the beds made and everything. Then you would put*

on a clean apron and bib and continue on doing the dressings.... The biggest thing you had to do was the dressings. Yes, and stoops. A stoop was a heavy blanket put in hot water. You had two sticks to ring it out and you would have to put that on somebody's leg, especially, someone with cellulitis... (Beaton & Walsh, 2004, p. 84).

As with many other aspects of health care, nurses have taken on more responsibility for wound prevention and management. The requirements of long term care facilities in Ontario to establish wound care teams (composed of RNs and RPNs, along with the dietitian and physician as ad hoc members) has forced the issue to some extent. However, as in other areas of care, expedience has driven this gradual change in roles of physicians and nurses. As in other areas of care, physician time is more costly (and less available) than nurse time, so the increased responsibility and involvement of nurses in directing wound care has become the norm. Nevertheless, traditional practice memories linger.

Margaret compares how providing wound care has changed since she first began nursing, almost twenty years ago:

Margaret, acute care:

I guess what I would say, the big difference is a much more relaxed atmosphere when it comes to me doing my wound care. Most of the nurses that I would see, now, are much more relaxed, they're not rigid. It's funny because at our hospital we have a physician who is very rigid. We quite often cringe if we have to have him involved with our wound care, because then we're not allowed the choices and being able to make the decisions like we can with our other peers, like *other consults.[laughs] You know, its not necessarily the doctor, in our circumstances, who is making the decisions around wound care, he's helping with them. Other than with our one physician here at this hospital, nurses are able to make those decisions and use products without orders, with consultation with the doctor. So that's been a huge change.*

The power of the physician to have control over decision-making around wound care has changed dramatically over the years, but other aspects have changed as well. People are "less rigid" as Margaret says. Her understanding of the ethos of decision-making, practice changes and the meaning of relationships is expressed in a way that infers collegiality, respect and communication.

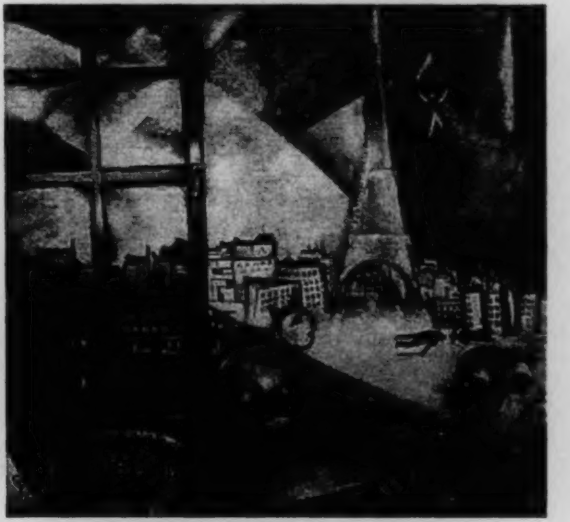
Barbara describes a physician who prefers 'his own way' of directing care, but the nurses have developed an approach that protects the patient and the physician at the same time: "we allow him …to try his way temporarily". The nurses use the time between the physician visits to the long term care setting to work around what they view as inappropriate:

Barbara, long term care:

We have one physician who is very good. Who just says, "Write it and I'll sign it. You know [what to do], just go ahead". Now we have the other physician who at some times is willing for suggestions, but a lot of times reverts to whatever he was taught or whatever he's heard or seen. But he's gradually getting better now that we bring out the books and things from what we've learned and say [to him]," well this is the way we've been learning". So he is getting better. (laughs)

He still likes to have, or we'll allow him, to try his way temporarily, we'll say okay let's try it for two weeks, if it hasn't healed then why don't we switch to what this [article] says and so I think he is getting a little better at realizing that you know, we've taken some type of education and things are changing every day and he maybe just isn't up on it.

As Merleau-Ponty found in his effort to describe Paris, it is neither easy nor perhaps necessary to dissect the topography of one's environment (in his case, Paris) in order to come to an understanding of what this place 'means': " Just as we do not see the eyes of a familiar face but simply its look and expression, so we perceive hardly any object… There is present a latent significance diffused throughout the landscape or the city which we find in something specific and self-evident which we feel no need to define" (Merleau-Ponty, 1962, p. 328).



Paris through the window, Chagall, 1913. Guggenheim Museum, New York.

Chagall's painting, *Paris through the window*, reflects this impressionistic, dreamy view of the city, touching fleetingly on landmarks, heart-felt places that the artist experienced and captured. In this painting, Chagall evokes his memory of romance (lovers floating below the Eiffel Tower), the excitement of the modern world (the parachutist) and memories of the past while looking towards the future (the Janus two-headed figure). For the viewer, the painting provides a wash of colour and images that evoke a sensual response. There are feelings of warmth, comfort, joy and spontaneity within this painting that can be readily accessed without the need for detailed analysis. In a similar way, the nurses in this study provided their impressions of the world in which they work. The meaning imbued in their work as nurses in all three settings resonated with the challenges of time and space. Like Chagall and Merleau-Ponty, the images the nurses created were evocative of their experience of work life, as it is lived in the day-to-day world.

Time and Space

This chapter contains the reflections of the nurses in this study who describe the world outside the wound in this way. Their view is the broad sweep of the work environment, yet for all three settings, the nurses express the interplay of the space (the environment) and time in moderating their relationship with patients. Nurses walk through their environment with their senses open, responding to what needs to be done to nourish, care for and protect the patient. There is a strong sense of commitment to the task that must be accomplished for the patient's sake. This appears built into how nurses describe what they do and how they do it. A resiliency within the descriptions transcends the mere task.

Elizabeth, long term care:

When you change a dressing, the residents can get very emotional at times. They need someone to sit there and hold their hand. Sometimes I wish I had more time to just sit and hold their hand because there's just the hubbub and the busyness and sometimes you forget that they're people and they live here. You need to go home at 3:00 p.m., but they're still going to be here. Most of them have families out there that you know they may not see every day or they're lucky if they see them once a year.

The nurses in this study reflected upon how they were situated within the work environment. Frustration often welled to the surface as they described how the uncontrollable world outside the wound confounded their attempts to do what they felt was the best for their patients. Interestingly, despite the differences in setting, the inability to control the world outside was a common thread for many of the nurses in this study.

Angela, long term care:

When you're an RN and in this role [in Long Term Care] you're in the capacity of charge nurse as well as a nurse. ..It's chaotic some days. You may have sick calls, you may have somebody wanting to go home sick, you might have family issues to deal with, resident issues to deal with…and then you've got 30 dressings to do as well. So, that's why I say when you get rushed, then there's that sense of being really pushed from outside yourself. It's chaotic and basically you don't have quite enough time that you wished you had.

Time Gets in the Way, it is Uncontrollable

The nurses in this study attempt to control the environment because they cannot control time. In acute care, it is the time constraints of patients requiring tests, medications or other care providers (e.g., physiotherapist, physician) as well as the acute needs of their other assigned patients. In long term care, the nurses are hampered by the time involved in other 'non-patient' responsibilities of the job. Community nurses have the unpredictable nature of the home visit that functions independent of any institutional schedule ("on it's own time"). Time flows on yet the nurses feel that if they can re-arrange schedules, hire more staff, or organize better, they will be able to conquer it. And, at the same time, they recognize that this is impossible.

Iris , acute care:

Don't tell anybody that you've got 15 free minutes, because as soon as you do somebody will find something for you to do-- and It's usually your patients, you know, so its difficult to say okay, yeah, I've got the time right now. I could go and find out the information, I could look it up on the internet or I could talk to a wound care specialist and we can come up with a whole plan of action of what to do to, what's the best action for this-- but then 15 minutes later I've got a patient who's having a heart attack or a patient who's come back from some test or I have a patient that right away needs direct attention. Well, that pulls you away from doing any education or other things. Its not like we're standing around looking at your patient and saying, ' okay, I only have one patient and that's you'.

Laurene, acute care:

I know on days when it's a nice workload its just seems more relaxed and not as rushed. Maybe I do a better assessment and probably don't appear as rushed and tense to the patients. I think they can sense that and but it is hard when you are really rushing and you say okay I have so much to do and I would like to get out of here on time, and I might like to go for a break. It's hard not to show that in your demeanor or tone of voice.

I notice it too and I get frustrated. I get frustrated with the patients, but it's really not their problem. I guess I just get frustrated with the job and not having enough time to do every dressing and assessment the same way as I would on a day that is really nice and a nice pace. That would be the nice thing to do.

Angela, long term care:

I guess I find nursing now a little bit frustrating because we're so busy. But again, we're busy because we get heavier care [patients]. I have 59 people. I'm the only RN on that's doing nursing and now we get people in with, it's not unusual, 10-12 diagnoses. You're dealing with really sick people and so you are really busy.

Susan, community care:

You can plan your day and…bang, it's just thrown out the window. You have a new patient and you expect one thing, you know, like a fairly straight-forward dressing and you get there and it's nothing like you expected. Maybe it's dehisced or just doesn't look right…You end up needing to stay longer, or phone the case manager or the doctor about it. A couple of things like that in a day, and you're way behind. It's frustrating, for sure.

Nurses express the desire to control the environment, to minimize the uncertainty of their work day so that they can effectively (according to their own expectations) provide care. The notion of control pervades much of nursing. The routinization of care through care maps, best practice guidelines and standardization of schedules for tests, medications, treatments and visitors, are the attempt of the health care 'system' to organize and manage what is essentially uncontrollable: aging, illness and disease.

As Frank (1991) points out,

> In society's view of disease, when the body goes out of control, the patient is treated as if he has lost control... Of course the problem is not that I or any other ill person has 'lost' control; the problem is that society's ideal of controlling the body is wrong in the first place. But rather than give up this ideal, society sends in [health care providers] to prove that bodies can be controlled. [Health care providers] justifiably think it is their duty to restore, in the name of society, the control that the sick are believed to have lost. Control, or at least management, becomes a medical ideal (p. 58).

Holly, a community nurse, describes how she plans her day, how she works to maintain the control of the care issues ("it's my responsibility") and how the plan can become sidetracked. She accepts the potential for uncertainty in her work day, but explained to me that this has come about only after many years as a community nurse.

Holly, community care:

Well, I start at 8:00 in the morning and I'm usually at my first call by 10 past 8, I work in one area, I don't move out of there. There are three other RNs in the same area, so I don't have a lot of driving to do, and I stay as little or as long as I need to stay. I couldn't work on a time frame. I would find that extremely difficult.

...I go and I do whatever I have to do with each patient. If they have no concerns that I have to stay a little bit longer I often will say to them, 'Well now, you know what happens to me when I'm late'. But sometimes I do a very silly thing, I ask them, 'Is there anything else?', as I'm going out the door, and it opens a whole new can of worms!.

She reveals an ability to accommodate to the needs of the patient, all the while recognizing the unrelenting nature of time. This skill demonstrates clinical phronesis, the wisdom of clinical experience that is developed through the interrelationship of means and ends that are directed by moral agency. As Benner states, clinical phronesis is the aptitude for "doing good in particular circumstances, where being in relationship and discerning particular human concerns are at stake and guide action" (Benner, 2000, p. 9). The nurses in this study reflected their concern for patients within the context of the embodied relationship that takes into account the temporal construction of the world around them.

Frances, long term care:

I try to go into each situation in the same way. I mean some people are much worse and some people have a very little wound, but it's still a wound and it's *still a person… You go into the room whether it's going to take you an hour or 5 minutes. Each person is allowed to have the same element of treatment. You have complex dressings that may take an hour, but then you'll have someone down the hall with just an itty bitty sore, but it's very, very excruciatingly painful for them. So that procedure becomes more time consuming than you originally thought because you have to pay attention to the other things, like dealing with the pain.*

Time, for nurses providing wound care, is linked to the desire to provide holistic care and the recognition that the wound has more complexity that the physical surface presents. As well, nurses in this study were aware of the need to address the busy-ness of their work in order to take the time required, yet the constraints of 'clock time' shackled the nurses to do the best they could under the limits imposed by multiple demands. The nurses described becoming more aware of the complexity of the wound and the management issues around treatment decisions. As their knowledge of treatment options increased, the time required to spend on wound management also increased. Thus the increased knowledge in wound care created time constraints of its own.

Thus it would seem that the world of the nurse is pushed by the external force of time, which affects entirely how the nurse sees him/herself moving through his/her day. Another component of this environmental experience is the actual physical environment in which the nurse involves him/herself with patient care. While the 'tools of the trade' might be similar, nurses in the three settings describe their environments in different ways.

Changing a dressing requires space. The nurse creates room for the equipment (dressing tray, saline, syringe to irrigate, scissors, forceps, gauze and assorted dressings), and establishes a clean field. While nurses attempt to control the environment around providing dressings, sometimes they cannot:

Roz describes an experience in community care where she was able to recognize that her patient's world required accommodation on her part:

Well I actually went into a home and this woman had about 200 cats. She had a packing dressing on the coccyx. She had two litter boxes that only used to be changed on Thursdays, so you can imagine the smell. She had kittens everywhere, I guess the cats were constantly having kittens and every time you'd go in you'd hear a constant growling and hissing…, I'm serious, this is just so freaky, this will always stick in my mind.

She loved her cats obviously, and I like cats too so I wasn't afraid to go in or anything, but when I went upstairs to do her packing and dressing, she had about 10 cats in the room with her. And so I set up my little sterile field and I was doing everything as clean as I could. There were about 5 cats on the bed and there was a little kitten chewing on the edge of my sterile field! I am serious, as I was packing her coccyx the kitten was chewing on the end of my sterile field. I mean what do you do in a situation like that, because this woman loves her cats so much, if you say anything to her she's going to freak out!

It is the relationship that takes priority here, the nurse is aware that it over-rides the temporal/spatial requirements of changing the dressing. The description Roz provides demonstrates how the *fellow-feeling* (Scheler, 1970) of the nurse manifests itself to support the patient, recognizing that rules are sometimes blurred or broken for more important reasons.

Deb, long term care:

[Mrs. M} wanted to know everything we were doing. It was so important for her to know if the wound was healing, if it was getting worse. It was like a play-by-play that she needed to hear. I guess if we'd had a camera, that would have been the best thing...but I just told her the details, as best I could. It was what she needed to hear.

Developing clinical phronesis involves contact with the patient. Beyond that is the collegial relationship with other nurses. Patricia Benner's works explore the development of clinical phronesis for nurses. She refers to the collaborative, collegial support described by the nurses in this study as the process of knowledge sharing during development as an expert nurse.

> Nurses need to collect examples of their recognitional abilites and describe the context, meanings characteristics and outcomes of their connoisseurship. This will enable them to refine their skills and to demonstrate or illustrate the qualitative distinctions they have come to recognize. Much of this takes place naturally as nurses compare their judgements…(Benner, 1984, p. 5).

For example, both Gabrielle and Elizabeth speak of the informal discussions around wound care that occur in the lounge or the treatment room where the nurses are able to share clinical insights in an atmosphere of collegiality.

Gabrielle, acute care:

Sometimes you'll be sitting in the lounge at break and someone will ask you how so-and-so is doing with that wound. They maybe had [the patient] last week and so she wants to know how the treatment is going… We talk a lot among ourselves about that. You worry over the ones that aren't healing or the ones we send off still in a mess… But sometimes, if the patient is there long enough, we get to see that what we're doing is working. Yeah, we talk about those too.

Elizabeth, long term care:

We'll [the nurses] go in the treatment room and say 'what do you think?' we'll talk about what we think we should be doing with a wound, or about the resident… I've been called to rooms, usually, only if the resident's okay with it, you don't want to have a conversation in front of them. Often times it's in the treatment room though, with the Registered Practical Nurses (RPNs). [They are] very good, if they notice something is different they'll come and say you know, this doesn't look right, either can you come look at it or this is what its looking like, what should I be doing. And then it's a learning process for them as well, so the next time they notice something is too dry or whatever, then they know what to do …

Beyond the Wound and the Patient, is the World of the Nurse

The community nurses were acutely aware of being visitors or guests in a patient's home. The control exerted by the nurse herself in attempting to manage the care issues (as Holly described) were mitigated by the patient's ability to control the environment. This arose by virtue of the fact that the interchange with the nurse occurred in the patient's own territory rather than in an institutional setting where the balance of power is weighted in favour of the institution/nurse.

For example, Roz, who has worked both in community and hospital settings, describes how the experience of being in the home with a patient creates a different response than caring for the patient in hospital:

Roz:

When you see a patient here in the hospital, I don't know that you really see the actual patient. [The nurses] see the condition and they see the wound that they have to change, and they don't really talk to the patient. They go in and say, ' okay I'm going to do your dressing now'. In the home you get to know the person because when you're in there doing somebody's dressing, ...they'll be talking to you about what they did yesterday and who's coming over for supper and their grandkids or whatever, so you get to know the actual person

The effect of being present in the patient's own home environment imbues the description with a sense of the nurse's own embodied response to this patient's experience. As Levinas (1985) suggests,

> It is through suffering that we overcome our isolation as atomistic individuals in a narcissistic world. The woven threads of loving witness, the sturdy presence of another consciousness, these gifts alone can embrace and comfort the one who suffers within a communion of selves (p. 45).

These words took me back to reflect on Baron's position (quoted in Leonard, 1989) that "it is nursing that seeks to help the patient reclaim that sense of embodiment that allows for their taken-for-granted, unselfconscious transactions with the world" (p. 47). Within the reflection of the dichotomous environments (hospital/home), Roz expresses how it feels to 'dwell with' the patient, to take the time to breathe in and recognize the uniqueness of the individual. The following poem describes some of these feelings as the nurse in the poem is brought to a reverie through the experience of changing a dressing.

A Story
On a gray morning
in an old woman's apartment
where he has come to wash
and pack the hole
her large right amputated toe
has left behind,
the nurse sits
on a cushion's broken springs
listening as she mourns her life.

That's when he feels his skin
start to crack and peel away
from hard bone,
a summoning of grief
from the gorged chambers
where a residue has collected
of those who vanished,
forcing him as a boy
to learn that death follows love
in many forms.

And for a moment

he's wandering hills of high grass
and manzanita,
gouging his initials into root stumps
with a rusted scout blade,
listening to wasps swarm
from their hive
buried in the ground
under a plywood sheet.
He sees the valley road
twisting back from sight,
the flash of sunlight off truck hoods,
wondering how he will find his place
in the world.

The wound is bright red
with a white border of flesh.
He presses gauze in gently,
feeling her leg flinch in his hands,
while a story is told on a day
already half-forgotten.
Beneath a window that draws in
the city's dull glare, their bodies
sink back forever into the room.

*Richard Callin, (*p.38, *Between the Heartbeats, 1995)*

In this poem, the nurse finds himself situated in the present, dressing a wound, but at the same time he recollects experiences of his own childhood that surface as the patient describes her own past, the sadness of memory. He too has memories that create a reflective, mournful bond between himself and the patient as he cleans and packs the wound. The touch of his hand on the patient's leg, his observation of the wound, bring him back to the present and the work-a-day world of homecare nursing. The poet/nurse finds himself already moving forward.

It is not true to the nature of human beings to maintain boundaries and isolation (Vanier, 1998). There is a risk of 'messiness' that nurses providing wound care seem unconcerned about, but it is the experience of intimate contact with another body that makes it difficult to objectify the experience.

Margaret, acute care:

...for the patient [the wound is] a huge issue. It might be the one thing that's causing stress in their life at this point in time. It's difficult to keep who we are and reflect it on them and make them try to be more like who we are, or try to see things from our perspective. And, as nurses, we need to learn how to see things from their perspective.

In the community, the nurse is faced with the patient's sense of entitlement within the home domain, where the ability to support the patient's perspective must be balanced by the purpose of the nurse's visit:

Pam, community care:

...They put a patient hat on when they're in hospital, whereas when they're at home they have much more control. It is their home and you do have to respect that, regardless of whether you would like to live the way they live or not...

Time to develop a relationship does not often occur in the hospital environment. In fact, hospitals do little to support relationship development between nurse and patient, as patient assignment is usually determined by location (proximity) rather than continuity of care. While this may be the nursing experience in acute care, it comes with a caveat.

Iris, acute care:

I find that for the 12 hour shifts it's much more difficult for that consistency, because you're only there two days and then you're off for two days. When I worked [8 hour shifts] I'd be there for 3-4 days or I might have 1 day off and then I was back in again, so you were able to be more consistent in the care that you gave.

Both community and long term care settings are environments more conducive to continuity of care and provide the opportunity to develop relationships with patients:

Susan, community care:

If I need to, I can confer with the doctor [over the phone], I can confer with my other colleagues [later on, back at the agency], but ultimately its my decision because I'm this person's nurse...That consistency that you've got, gives you the opportunity to see what you're doing, either working or not working, day after day.

How Time and Space Affect the Relationship

Hazel, a community nurse who has also worked in hospital settings in the past:

You go into someone's home and you don't have call bells ringing, you don't have doctors tugging on your sleeve telling you to come and write these *orders, you go in, you do what you need to do, you focus, you do a good job, then up and then you go to the next.*

I was finding that working in a hospital, you'd get home after a night shift and you'd be lying there in bed trying to get to sleep and you're remembering, "oh what was it she asked for last evening, was it a newspaper so she could catch up on the news?" And you didn't do it because you didn't have time.

Roz describes her experience of working in all three settings. She spoke wistfully of the missed opportunity to follow the patient's progress in the hospital. Having experienced all three environments, she was able to identify the disconnect she felt working in the hospital. She was accustomed to the slower pace of building and developing a relationship with her patients and expressed how different things were in the hospital.

Roz:

I worked in long term care for years before and you know, it was the same thing there too, you did somebody's dressing and you could see it slowly getting better you know, it's the same thing with the home. In the hospital, it's different because they come and you do their dressing for a day or two and then they're gone, you know. Unless the people are here for a long, long time but then you don't always get the same patients.

It's hard to see that. I was used to getting to know the patient, their life, their family. The dressing change was just a small part of it all, really.

Relationships

The nurses in this study responded to the patient through an embodied relationship that encompasses " an attitude of involvement and openness to the total life world of the patient" (Gastmans, 1998, p. 1314). This relationship, of "fellow-feeling" as described by Gadow (1980) is not one's own feeling but the explicit recognition of the other's (i.e., patient's) feeling. To this end, the nurse must be able to authentically go outside her own understanding of the experience and 'dwell with' the patient and his/her experience.

One of the nurses speaks of how she is able to simultaneously assess and reassure the patient as she prepares to change a dressing.

Laurene, acute care:

I just talk to the patient and ask questions about pain level and how they are eating and kind of tell them what I do. I do all that while I'm assessing at the same time, I guess because it reassures [the patient] instead of just going in and looking, which makes their anxiety level go up. I find it easier to reassure the spouse too--often they look like they are kind of in shock (laughs), and the nurses are the same way too when you take them to show them a wound like that is maybe something they have never seen before. So I guess I am looking at it as kind of a problem I want to fix and the best way to do it…

Nurses can itemize their activities, recalling each one with detail and familiarity. Yet each activity, each event, pulls us into their description of the day or the night in its totality. It is this elaboration of the environment that provides an image of what this world is like, just as Chagall's painting of Paris creates an image through which the artist's experience of the city can be understood, through the viewer's own lens.

I shared my perceptions of what I had been observing and hearing with one of the nurses in the study:

It seems that time has a different quality, a different meaning… so despite the fact that the nurses might be pressured to do the dressing, because they're the only ones doing the dressings and the treatment, the way time is seen, is still very different from the hospital or the community. There, the nurses are much more focused on the time, like, "I've only got x amount of time to get this done and get on with things", whereas here [in long term care] what I see is people paying more attention to the human side of what's going on and so recognizing, that the value is in not just in getting the task done, but also getting the task done relating to that whole person at the same time.

In acute care I see often what happens is that the nurses have a limited, a really limited amount of time. They've got to get their patients done, they've got some test that they're going for and so they have to be ready to go. And in order to get them ready to go, the nurse really hustles to get the dressing done. Often at the expense of being able to focus on that whole person…

Her response:

In long term care, it's true, we have more time, maybe not in one day—sometimes it is so busy you fly around—but we have the luxury, I guess you could call it that, of developing this relationship with the residents that can last for years. We have people who live with us for ten, twelve years sometimes. You really get to *know them. So if you see them with a wound, you see the person first, because you know them. And if I don't have time to spend today, I know I will be able to spend time later…sometime later.*

It is the nurse who carries the patient's wound and the patient's world with them as they attend to the work of providing care. Despite the challenges of time, space and relationships, the nurse remains vigilant and attuned to the unspoken and intimate needs of the patient. Nurses find themselves in the dark hours of the night and early morning, as the solitary messenger who can take the fear and pain of the unknown experience, and dwell with the patient or the patient's family as they struggle through. Many times, it is the nurse who bears witness to the horror of the fungating wound or who is there as the patient draws his last breath. The real quality of these 'present moments' is difficult to capture. The poem, *This Happened*, is one such experience, told from the nurse's point of view. How nurses begin to search for the words to share the richness and the importance of the relationship between themselves and their patients, is part of what I have learned to value from this study.

This Happened

The intern and I begin our rounds.
In room two, the intern watches me;
he doesn't like this patient anyway—
she's messy, a see-through plastic tube
pulls bile from her stomach
to a bottle near her head.

A small balloon inside her throat keeps pressure
on vessels wrecked by years of gin.

The patient's wide awake,
But she can't talk.
I see her eyes open, her skin

pale at the moment these veins
blow, like a tire blows.
Blood backs up her nose.

She tries to sit;
her wrists are tied.
I take her hand and say, *OK, OK.*

The intern leaves.
Next the patient's gut lets go.
Stool and blood clot between her legs,

Hot and soft, not like sex,
More like giving birth. *OK,* I say.
We let our fingers intertwine.

By 8:15 the woman calms.
Clots thicken in her throat;
she holds her breath.

At nine, blood coins
close her eyes. I breathe deep,
stroke the patient's arm.

artist experienced and captured. In this painting, Chagall evokes his memory of romance (lovers floating below the Eiffel Tower), the excitement of the modern world (the parachutist) and memories of the past while looking towards the future (the Janus two-headed figure). For the viewer, the painting provides a wash of colour and images that evoke a sensual response. There are feelings of warmth, comfort, joy and spontaneity within this painting that can be readily accessed without the need for detailed analysis. In a similar way, the nurses in this study provided their impressions of the world in which they work. The meaning imbued in their work as nurses in all three settings resonated with the challenges of time and space. Like Chagall and Merleau-Ponty, the images the nurses created were evocative of their experience of work life, as it is lived in the day-to-day world.

Time and Space

This chapter contains the reflections of the nurses in this study who describe the world outside the wound in this way. Their view is the broad sweep of the work environment, yet for all three settings, the nurses express the interplay of the space (the environment) and time in moderating their relationship with patients. Nurses walk through their environment with their senses open, responding to what needs to be done to nourish, care for and protect the patient. There is a strong sense of commitment to the task that must be accomplished for the patient's sake. This appears built into how nurses describe what they do and how they do it. A resiliency within the descriptions transcends the mere task.

Chapter six: Hearts, Hands and Minds.

[The nurse] must have a respect for her own calling because God's precious gift of life is often placed in her hands; she must be a sound and a quick observer and she must be a woman of delicate and decent feeling".

Notes on Nursing, Florence Nightingale, 1859, p. 126

Leonardo daVinci: Study of Arms and Hands, c. 1474 Pinacoteca di Brera, Milan, Italy.

Nursing is a clinically driven profession with its roots in the nurturing care of tending to the sick and wounded. DaVinci's study of arms and hands, reproduced above, illustrates the beauty and the power of hands in repose as well as carrying out the tasks of every day living. As I work with patients, assessing wounds, changing dressings, I am acutely aware of the physical requirements of my hands in irrigating, debriding and dressing a wound. As I assist patients to re-position, I touch their bodies with my hands. I feel the connection of my gloved hands on their skin. Not only am I aware of the physiological signs that I am assessing as I touch the patient, I am also conscious of the nature of the connection my touch creates.

Hands are a conduit for care. As Dr. Bernard Lown (1999) says,

> …the oldest skill was the laying-on of hands. Until [the 20th Century] relatively little else could be done in most cases. With the passage of time, this simple act of compassion was transformed into an art. Eventually it grew into a scientific skill, and the hand became an important diagnostic instrument…Touching has become perfunctory as the physical examination has grown increasingly cursory (p. 28).

Nurses, however, by the nature of the intimacy of their involvement with the physical needs of patients (elimination, defecation, cleanliness, mobility, dressings) have retained the opportunity to have a meaningful connection with a patient through this skin (or glove) on skin interaction.

The phenomenological exploration of nurses' experience of changing a dressing has revealed that when given the opportunity to speak, nurses are aware of how they move within the world of wounds and patient care. This final chapter is a reflection of the hearts, hands and minds of nurses.

The experience of using an interpretive phenomenological approach to study the topic of changing a dressing has been a challenge. As van Manen asserts, there are no finite answers or solutions when using this approach. "The point is that no conceptual formulation or single statement can possibly capture the full mystery of this experience" (1997 b, p. 92). Rather, it is a way of unlocking hidden perspectives, providing the opportunity for expressions of thoughts and feelings that nurses are not accustomed to speaking aloud. The nurses in this study were often caught by surprise at their own words and response to the simple question, "what is it like to change a dressing?"

Gabrielle, acute care:

" I didn't realize I had this much to say…I've never really had the opportunity to talk about what I think about nursing and what I do as a nurse… I guess I didn't realize how strongly I felt…or maybe I did, I just didn't have the words to say it, or thought anyone would be interested in hearing it"

Elizabeth, long term care:

It's neat talking to somebody about [changing a dressing]… we don't talk about it. I think we talk about how terrible our day is and oh we had this to deal with and that, but we don't always think of the positive things, like we made sure, Mrs. P's dressing drained less today. That is exciting, you know, it stayed sealed for 48 hours and we're really excited! (laughing). …We healed this wound! Those are things we should be celebrating, I mean, obviously something has gone right.

This perspective is echoed in Shakespeare's (2003) contention that

> Much nursing body work is taken for granted…If we go looking for it, we can find it, it can be inferred, but it is not reportable in its own right. Following from this, we might suggest that in the literature there is almost the 'shadow' of nurses' bodies and embodiment waiting to be discovered (p. 48).

While researchers attempt to understand what nursing practice and the nursing environment mean to nurses, the approach of descriptive studies, questionnaires with open-ended questions and rating scales seem to miss the wholeness of meaning. Nurses, reading of themselves in the nursing literature, may come to expect a paler version of themselves. When given the opportunity to speak unfettered, they may be, as Gabrielle, surprised by their own words.

I too was not expecting the powerful sense of connection the nurses felt for the work they do, for the patients they tend. My clinical observations of nurses changing dressings along with the over-all thrust of nursing literature on the topics related to wound care led me to conclude that nurses, in general, found wound care to be a time consuming and distasteful task.

Lawler suggests that nurses use ritualized procedures and speed to hurry through an uncomfortable, highly intimate experience, such as changing a dressing. As well, she asserts that nurses disengage.

> Lack of affect is a means by which nurses construct context, so in that sense, it serves to assist in the management of otherwise potentially embarrassing situations. The problem for RNs however is that lack of affect can become *the* standardized and expected emotional response (1991, p. 129).

Hana, the young nurse in Ondaatje's *The English Patient* has seen so much of the carnage of war in the wounded soldiers she tends:

> Caring was brief. There was a contract only until death. Nothing in her spirit or her past had taught her to be a nurse… Throughout the war, with all of her worst patients, she survived by keeping a coldness hidden in her role as

> a nurse. I will survive this. I won't fall apart in this. These were buried sentences all through her war…(1992, p. 48).

Hermeneutic phenomenology involves the divesting of assumptions and biases as the researcher prepares to become open and non-judgmental. "One begins to become less assuming, often abandoning assumptions about another or another's experience, and adopts a stance of 'unknowing' (Munhall, 2001, p. 135). As the researcher, I felt that I had divested myself of these assumptions as the conversational interviews with the study participants took place. I became aware that the nurses in this study were not responding to the wound or to the patient in the ways described in much of the literature. In fact, these nurses were keenly aware of the impact of the wound on the patient's life.

A major impetus in coming to this research was that my observation of nurses dealing with dressing changes reflected the findings in the literature that nurses were either unaware of or unconcerned with the patient's pain. Within the interviews of the nurses in this study, it became clear that while they recognized pain as an aspect of the patient's experience of the wound, it was not the focus of their attention. It seemed that it was less important for the nurses in this study to isolate and describe their experience of the patient's wound-related pain than it was to focus on the protective nature of their role in dealing with the visible, tangible and visceral dimensions of wound care.

Pain did not appear to be the significant responsive touchstone for the nurses interviewed for this study. In part, this may have been a feature of the level of clinical experience of the study participants, whose responses to the research question implied an assumption (as seasoned nurses) that the issue of pain management would have been attended to *prior* to coming to the actual dressing change. Rather, the focus was on protecting the patient from the emotional distress caused by the wound's presence, odour, drainage, location and especially, the significance of the wound for the patient.

Hazel, a nurse from acute care:

"[With more experience], I was more organized and had more time to think about the other issues, like what can I do better for this wound or does this person need sedation. I could talk about other things and reassure [the patient] while actually doing [the dressing]... I guess it's easier when you get more experience under your belt and you know how to treat the different wounds. Then you can deal with the other aspects—social, emotional".

For these nurses, the meaning of changing a dressing included the world of the wound itself and the world of the patient. While they were attuned to the physiological events (e.g., granulation or infection within the wound) at the same time, they were vigilant for events within the patient's world that required their attention. Just as Hanna, the nurse in *The English Patient* (Ondaatje, 1992), sits and reads to the burned man, or washes him, or peels a plum to feed to him, she watches over him, tuned to the rhythm of his needs. This understanding of the patient's real life world demonstrates the perceptual acuity of the expert clinician who lives an embodied practice of care (Benner, 2000).

Elizabeth, long term care:

I think of the lady who has the wound that we're never going to heal. We're there to provide comfort to her so that... collecting all this drainage is not so hard on her... she's also palliative so... you're trying to provide all her care needs, not just the task of doing this wound.

Holly, community care:

I don't think it's the actual wound itself that's the draw, I think it's a sense of the holistic approach, that I've always done... I think I care, number one. I do actually care for my fellow man. I have a lot of empathy for people. I enjoyed my training, which was hospital based. I started with children and babies and I loved the babies, you give your whole heart and soul to them, and I think that's where it starts, if you have a good experience at the beginning of your training, its going to carry you right through.

Nursing has often been described as a hands-on profession. The nurses in this study felt strongly that the 'laying on of hands', this intimate touch, connected them with the patient and the patient's experience. This aspect of nursing most powerfully defined who they are as nurses. The ability to touch and interact in this physical way manifested and exemplified the healing, caring aspects of the role of the nurse. Far from being repulsive, the act of changing a dressing gave these nurses a sense of accomplishment and control:

Barbara, long term care:

It's amazing that something has gone wrong on a person, such as the ulcer or incision, and be able to put forth a process and to watch it heal, I think it's amazing. Because that's what you want to do, you want to help as a nurse, to help everybody.

Nurses see themselves as being actively engaged in the therapeutic relationship with patients. It is the activities involved in this relationship that provide nurses in this study with a sense of accomplishment, as Barbara describes. The nurses feel that their ability to provide "hands on care" that is skilled and responsive to the wound assists the patient, whether or not the wound itself can be healed. This approach to the task of dressing change is focussed on the interaction between patient and nurse.

Peplau (1952) describes this level of interaction as the key to developing a therapeutic relationship. " It can be pointed out that [italics author's own] *the operations involved in the nursing process are interpersonal and technical ones,* but that the process itself cannot be defined as technical" (p. 5). Peplau goes on to state that it is the interaction between the patient and the nurse "are often more telling in the outcome of a patient's problem than are many routine technical procedures" (p. 6).

Elizabeth, long term care:

Some people think this [changing a dressing] is just a task...but to the resident, the wound is something they're concerned about. It's part of them, often a part they can't see...So you have to describe it[to the resident], if it's doing better *or worse, why they have to take vitamins or have that particular dressing. You need to be seeing more than just the wound on them...*

Carol, long term care:

One of the important things is to remember [the patient] as a person and why you're doing the dressing and how they feel, because anybody can really be taught physically how to do a dressing. But I think...you have to realize this person may inside be dealing with some issue while you're changing this dressing.

These nurses are able to recognize the essential duality of the patient's body: the lived body of consciousness and the object body of functional values. As Gadow (1980) states, " nursing provides care and cure, intimate concern for the lived body and scientific treatment of the object body" (p. 98). In a sense, it is the nurses themselves who 'get under the skin' of the patient, as they understand the fundamental connections between their observations of the wound and the actual lived experience of the patient.

Experience plays a role in how the nurse responds to the patient. Using Benner's novice to expert nurse descriptions (1984), it is clear that the nurses in this study understood the evolution of their practice. Laurene, an acute care nurse, described her journey from novice to expert as she began to provide care to patients with wounds:

Laurene, acute care:

[When you start out as a nurse], you are going in and thinking this is a pressure ulcer, this is a gallbladder incision, this is what I need to do... Then you

start learning… to deal with the whole picture more. I didn't do that at first because it was just overwhelming as a new graduate. To actually [treat the patient holistically] is hard at first until you get some experience. It's a lot to learn to deal with the physical things or what to do with different dressings. It is easier when you get more experience under your belt and you know how to treat different wounds. Then you can deal with the social and emotional aspects.

Embodied, expert nursing that engages in relational care demonstrates the nurse's own growth and maturity. "Regarding the patient as a 'whole' would seem to require nothing less than the nurse acting as a 'whole' person" (Gadow, 1980, p. 87). It is the readiness of the nurse herself to enter into the relationship on this level that creates the setting for professional involvement. This readiness is mitigated by the nurse's level of self-insight (Peplau, 1952) which engenders both interpersonal and transactional engagement.

The nurses in this study gave descriptions that reflected their appreciation for the skills required in wound care.

Kris, community care:

I became a nurse because I wanted to help people and being able to see how I can help them with their wound care. It really means a lot to me, especially when I can improve their quality of life… and I want to do the best possible job I can with helping my patients. If I can relieve them of pain or decrease the number of times the dressing needs to be done, I feel like I've done something positive for them.

Kris describes the experience of changing a dressing as physical task that has meaning invested in it. For the nurse herself, changing the dressing is an opportunity to "be a good nurse". She is able to decrease the frequency of dressing changes and decrease pain, both of which are nursing actions that demonstrate skill (of observation, intervention and evaluation). At the same time, Kris recognizes that these actions provide relief for the patient on more than a physical level: she understands how decreasing dressings will affect the patient's experience of pain and thus improve his quality of life.

The descriptions of "hands-on" care is not limited to the technical side of wound care but is used as a way of invoking language to describe the intimacy of the dressing change.

Susan, community care:

[Wound care] … is really quite a challenge because we are dealing with people and it is, I hate to say it but, trial and error. What works for one person may not work for another person, so this job is a very challenging job. I am always having to problem solve and think of new ideas. As well, you have to find out the history of this person, you can't just look at the wound, you have to look at the whole person… You may find that there is another stress in their life and you have to deal with the stress that they are dealing with in a sensitive way. It may be that they lost their spouse, or even a pet, sometimes that can be very hard on people but they think they shouldn't be so upset. You have to be sensitive to them, tread lightly. That can be a challenge too.

Deb, long term care:

You know, everybody can follow instructions, that's the simple part, it's the other part, the more complex issues that you have to watch for I think when you're *doing wound care. [For example], going in to see a resident who has had lots of different people in to change the dressing and there is a new person, me, coming in to change his very personal wound. When you go in as the new person, you aren't familiar to that wound, you don't know how they got this wound. You have to be aware of where you're coming from and get to know [the resident]on a different level other than just the wound and this is what I'm going to do to it. They're still a person, you have to always keep that in mind.*

As well, it was evident that the constraints of time and environment/space did create barriers to their ability to provide what they considered optimal care. When this occurred, the nurses expressed their distaste for their inability to overcome the barriers, but at the same time, they recognized that control of the world beyond the wound, or even of the wound itself, was not always possible.

Barbara, long term care:

Oh it's awful. I don't feel like I give [patients] the proper care necessarily during their dressing change. You go in, you tell them you're going to do it, you do it, you're out, that's it, you don't take the time to maybe investigate it as much as you'd like to or you know, or even just spend the time with them seeing what kind of pain, carrying on a real conversation with them. A lot of times, you don't take what you need and I find myself running back and forth a lot.

Gabrielle, acute care:

The options are running out as to what could be done, because …we tried every type of dressing that we could, she'd been to hospital and back, debridement, she'd had oxygen therapy and she was just back to us and the last option would be *amputation. And that's what they were trying to persuade her, I mean that's the last thing you want for your patient, but then sometimes you know, when you've been doing this dressing for so long, with nothing improving... you think, ' wouldn't it be for the best, really'.*

Both Barbara and Gabrielle speak of the closeness of their relationship with the patient, as nurses with the maturity and depth of understanding that is part of the clinical wisdom of expert nurses. Joanne, a nurse in the study, with beginning experience and limited 'real' knowledge, spoke of her reaction to wounds and wound care:

Joanne, acute care:

I never imagined that people could get an ulcer that covered their whole entire buttocks! It never crossed my mind. I had a lady in the hospital that had the flesh eating disease, she had a back dressing and even though most of it had healed, the skin was off one leg, down the other leg. To me, wow--you don't think that things like that happen. If you didn't work in a hospital you would not see any of that because you are not going to see that lady out in public.

It was a transformative experience to appreciate that these nurses experienced changing a dressing as an activity that had important meaning for them. As they spoke to me during the interviews, their perspective moved from the particular recollections of specific experiences of changing dressings, to a wider dimension. It was as if these nurses were seeing themselves for the first time and realizing that they liked what they saw.

Barbara, long term care:

I think the things with wounds is you can watch them at the worst stage and know that what you're doing each time you change it is helping them, watching it heal. And you feel a feeling of accomplishment. Wow, you know, what I did mattered and it was successful. I think as nurses, we like knowing that what we've done has been successful and helps somebody.

We can give medication till we're blue in the face sometimes and we're not sure exactly what it's doing within—okay, with blood pressure medication, there is some evidence, but the actual visualization of something healing…is an accomplishment, it's like a pat on the back that we give ourselves because all we've done is heal. That's how I feel.

How the nurses worried, cared and supported their patients and their wounds reflected this deep, essential feeling for what it is nurses do as they provide wound care. It is what these nurses described, defining themselves as the great satisfaction of nursing: why they love being nurses. This is not to say that frustration over time constraints, inconsistency of care providers, and limitations of knowledge were not significant to these nurses.

Deb, long term care:

There's a lot more to it all. The awareness of them being them, that they are a person, its not just come in, look at the foot and leave… They're a package deal and they need a lot more than what they get. It's too bad, like I said, the time factor, that's the only one thing I think is disappointing about nursing is there's just not enough time…

I think all nurses feel that they wish they could do more.

The nurses in this study felt that changing dressings was an intellectually stimulating activity as the wound and the patient are assessed and hands-on nursing care provided. The nurses describe the excitement they felt at this use of their intellectual powers of learning, observation and experience:

Hazel, community care:

I like the challenge of putting all of the pieces together,... you're able to pull everything all together, think on your feet quickly, and then transpose that into what are we going to do from here, what's our best way to deal with [the wound]. Not that I don't do some experimenting still, thinking , hmm, let's try this...

I've been finding that what I've been doing is working for the major part, and that really spurs me on, it makes me feel good about myself and it spurs me on to continue on with my education.

Barbara, long term care:

It's like a specialty area to be able to provide good wound care for people. I like it because it is a very personal thing to do for your patients and residents. I like it because it's complex, it keeps your knowledge flowing because, as you know, wound care products and methods are changing all the time so you're always learning new things about it.

For the nurses in this study, the meaning of the lived, every day experience of changing a dressing was expressed through the lens of meaning they ascribed to being a nurse. As van Manen points out, the reduction of phenomenological research is located in a particular vantage point (1997 b, p. 40). The nurses spoke of the meaning of changing a dressing and the meaning this had for them as nurses:

Hazel, community care:

We really want to make a difference and we really do care. Our hearts get broken on a daily basis sometimes, because we run up against road blocks and we get put down for really trying. But that's why we come back because we really do care, God dammit ! You know, we do. We really do, and that's hard at times. Nurses are good people, nurses are really good people.

But it's hard to get that across sometimes. Nobody knows what we do, they don't want to know, even if you want to tell them! (laughing) And sometimes you don't even have the words. You don't have the words to describe what it is that you really do. It's a lot of soul searching and it's a whole breed of people. It really is. I'm proud to be a nurse.

These comments resonate with me. There are only a few phenomenological studies that explore the meaning of care from the *nurses'* perspective (Russell, 1994; Peeby, 2000; Maeve, 1998). In the evolution of his/her practice, the nurse moves towards colleagues. Support and sharing experiences are important for nurses, but remain hidden in the background of nurses' work. According to Lawler (1991):

> Nurses find it difficult …to talk about their work with anyone other than nurses, and this is a direct result of the extent to which their work involves aspects of life which are considered dirty or which are too close to aspects

> of sexuality for some people's comfort. In this respect…nurses conceal their work… (p. 219).

As Shalof (2004) writes:

> Our group, Laura's Line, all worked the same schedule, so we were also off on the same days, too. Sometimes we met for lunch…Each time we vowed we wouldn't talk about work, but inevitably and within minutes, our conversation drifted in that direction. Who else knew what we had seen, what we had experienced? To whom else could we unburden ourselves? Who would want to hear? Who would understand? (p. 71)

Laurene, acute care:

I think you probably discuss it amongst your colleagues, but you wouldn't take it home and say "oh, well this happened to me today" because they would just be shocked and sick… I'd talk to my colleagues. They probably have experiences something similar or tell you something that was just as horrendous! But yeah, it's something you wouldn't discuss outside a hospital really.

Within these works, there is an underlying theme that describes how nurses, when given the voice to speak about their lived experience as *nurses*, describe the power of mind, hands and heart as the motivator and truly satisfying feeling of being a nurse. This study has provided similarities as these nurses describe not only their task-related functions of providing wound care, but weaves together mind-hands-heart in the provision of this intimate, satisfying care.

Iris, acute care:

I don't think nursing is our job, I think nurses are who we become. It's not easy. If we try to break that, turn that nurse on at 7:30 and turn that nurse of at 7:30 pm, we're going to kill ourselves doing it, because you have to take that into your whole life, you have to become who you are. And I think the nurses that do it very successfully, they've been doing it for very long periods of time, and I think nurses who continue to challenge themselves are the ones that continue to grow in that role.

Conclusion

The purpose of this study was to open doors and windows for the reader to better understand the meaning of the lived, everyday experience of nurses changing a dressing. While the impetus for the study was based in my observation of nurses carrying out dressing changes in a perfunctory and disengaged manner, I was surprised by the outcome of this study.

The nursing literature regarding management of wounds, including pain management, is replete with conclusions that nurses undertreat and undermedicate patients. These outcomes, along with my own clinical observations, led me to wonder what nurses experienced when changing dressings. I knew my own response was not one of disengaged or disinterested care and I wanted to see if the research literature coincided with what nurses themselves actually experienced.

I must admit, I was surprised by the powerful responses of the nurses whom I interviewed. While they recognized the enormous barrier of time and their attempts to control the environment, they spoke as if with one voice, of the profound respect and caring they have for their patients and their families. Irrespective of setting, these nurses expressed the value of relationship and of understanding the embodied needs of the patient around wound care.

Nursing care has primarily focussed on the tasks required of nurses to do their work. While lip-service has been paid to the notion of nursing as an "art and a science", little within the existing nursing literature explores what nurses think and feel the job of being a nurse is like in clinical settings. It is true that many studies have been conducted regarding the nursing role and nursing workplace, but these studies have used methods that perhaps are not conducive to questioning how nurses experience the various aspects of nursing. As Lawler (1991) states:

> I am even more convinced that what separates the (proper) nurse from those who are technically competent to perform nursing care is not *what* is done, but rather *how* it is done—that is, nursing is a more social entity than anything else (p. *vi*).

The nurses in this study demonstrated this conviction in that they too expressed the belief that *nurses are who we become*.

But the purpose of this study is not to provide definitive answers. This study was an exploration of changing a dressing from the perspective of nurses who live in the real clinical world of time, space and relationships. This study was not intended to be generalized to a different or larger nursing cohort. However, I believe that the method of hermeneutic phenomenology is an approach that can unlock much of the hidden world of nursing.

Conducting this study altered my own perspective of how nurses appear as they provide care. The ability of the participants in this study to articulate their deeply felt responses to the needs of their patients demonstrated to me that despite the sense of compressed time and added responsibilities, nurses were undeniably attuned to their patients. In my own clinical practice, the outcome of this study has been a realization that the nurses with whom I work are imbued with the positive attributes of caring and compassion. This awareness has provided me with a an approach to create opportunities to enhance their experience of changing a dressing that truly unlocks the potential for real engagement between patient and nurse.

Implications for Nursing and Future Research

It would be of value to use this knowledge as a means of revealing the unspoken experiences of deep caring that nurses may in fact keep hidden from view. Hermeneutic inquiry provides a powerful tool for researchers to aid in the interpretation of experience, for the participant and the researcher. The results of studies such as this one can then be used to cultivate self-awareness and provide a supportive, positive approach to improving care—because nurses clearly do care.

Possible future research endeavours based on this study might include expanding the participant experience to focus on male nurses, students and novice nurses since individuals within each of these groups may provide perspectives on wound care which would add to the body of knowledge and offer insight into the lived experience from these differing points of view.

As well, phenomenological studies of the experience of patients and their families within the context of wound care (living with chronic wounds) would be valuable. As nurses work at the bedside, in the community or in long term care facilities, the voices of patients and their families need to be heard. These studies could be used to create an environment open to change, through focus group discussions, for example, which in turn could lead to effective implementation of nursing practice guidelines.

Within this study, the nurses were given the opportunity to delve introspectively into their work life. I am grateful to these nurses for taking the time and effort to meet with me to talk about their world. Their voices, printed on these pages, reflect what nurses know within themselves.

The poem with which this dissertation concludes reflects the overwhelming sense that the nurses who participated in this study were deeply 'in tune' with their patients, whether or not they could articulate or express this while they were actively involved in providing care. The abiding understanding that the wound belongs to the patient and should be treated as part of the whole person, was a strong message from these nurses.

Wounds and wound care are complex, personal, intimate and challenging. Keeping in touch with the situational suffering of the patient and the mitigating efforts to care, to touch and to reach out, are these nurses' expressions of passion and compassion that are reflected so beautifully in this poem.

The Demonstration

Threads of blood arc
as I peel away the bandage
from the tumor on his neck.
          He cannot speak.
He writes furious notes—
how yesterday
I spread the lotion
so thick it melted
all day in sticky rivulets.

His lover takes the jar.
Tenderly she lays the salve—
a glittering film
across the gray crevices.
Over and over her arms
circle him in an embrace
of trailing gauze that buries
the strangling mass.
A hump she tapes and strokes
as if it were their child
          she dressed.

How will I chart?
That she needs more instruction?
That she forgot her gloves?
That it doesn't matter?

Dawn Ramm, (Between the Heartbeats, 1995, p. 146)

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Appendix A

Letter of Invitation to Participate

Study title: Changing a dressing: the nurse's experience.

Investigator: Rosemary Kohr, RN, PhD Candidate

Faculty of Nursing, University of Alberta

Phone: 519-642-7999 E-mail: rosemary.kohr@lhsc.on.ca

Co-Supervisors: Drs.Kate Caelli and Rene Day,

Faculty of Nursing, University of Alberta

Phone: 1-780-492 4742 E-mail: kate.caelli@ualberta.ca

Phone: 1-780-492 6785 E-mail: rene.day@ualberta.ca

As a nurse who looks after patients with wounds you are invited to join in a study I am doing as part of my PhD program.

The purpose of the study is to understand and describe what it is like to give wound care, in particular what it is like to change a dressing. I want to understand what this experience is like. In this study, you will be asked to talk about your experiences of giving wound care. The conversation will last for about 1-1 ½ hours.

It will be tape-recorded and then typed. I will interview you at a time and place that will be best for you. If I have more questions, I may need to talk with you again.

You do not have to be in this study if you do not want to be. If you do want to leave the study—which you can do at anytime—you just have to let me know.

There will be no harm or direct benefit to you if you are in this study. Results from this study may help nurses, doctors, and the public at large, learn more about looking after patients with wounds. It might also help nurses give better care to patients with wounds.

Your real name will not be used in this study. Only a code name will be used for any part of the study. Your code name will be used for the taped interview and when it is typed. Your real name and code name will be kept in a locked cupboard and I will be the only one with the key.

The information and results of the study will be written up to be published and may be presented at meetings. I will not use your name or anything that would show your identity. If there is anything you want to ask about this study at any time, you can call or email me or my supervisors at the phone numbers or email addresses given at the top of the page.

If you would like to be part of this study, please call or email me.

Appendix B

Information Letter for Participants: Research Conversations

Title: Changing a dressing: the nurse experience.

Investigator: Rosemary Kohr, RN, PhD Candidate

Faculty of Nursing, University of Alberta

Phone: 519-642-7999

Email: rosemary.kohr@lhsc.on.ca

Co-Supervisors: Drs.Kate Caelli and Rene Day,

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Phone: 1-780-492 6785 Email: rene.day@ualberta.ca

The **purpose of the study** is to understand what it is like to give wound care. The study asks you to describe what it is like to change a dressing. I want to understand what this experience is like.

What will happen in this study? In this study, you will be asked to talk about what it is like for you to give wound care. You and I will talk for about 1-1 ½ hours. The conversation will be tape recorded and then typed. I will interview you at a time and place that is best for you. I may need to talk with you a second time.

Staying in or Leaving the study: You do not have to be in this study if you do not want to be. If you do want to leave the study, you can do so at any time. You just have to let me know.

What can happen if you are in this study: Nothing will happen to you, good or bad, if you are part of this study. Results from this study may help nurses, doctors, and the public, learn more about looking after patients with wounds. It might also help nurses give better care to patients with wounds.

Making sure of your privacy: Your real name will not be used in this study. Only a code name will be used for everything. for the taped interview and when it is typed. Your real name and your code name will be kept in a locked cupboard. I will be the only one with the key. The typist will sign a form to say that she will not tell anyone anything she hears on the tapes.

The results of the study may be published or presented at meetings. Your real name or anything that links you to the study will never be used. If there is anything you want to ask about this study at any time, you can call me or my supervisors at the phone numbers given at the top of the page.

If you want to be part of this study, you will be asked to sign a consent form. You will also be asked to think of a fake name that will be used for anything to do with the study. Your real name will not be used at all.

I may want to use the data from this study for more research. If you agree, I will make sure that I get approval from an ethics committee before I start that study.

Appendix C

Consent to Participate in Research

Title: Changing a dressing: the nurse's experience.

Investigator: Rosemary Kohr, RN, PhD Candidate

Faculty of Nursing, University of Alberta

Phone: 519-642-7999 Email: rosemary.kohr@lhsc.on.ca

Co-Supervisors: Drs.Kate Caelli and Rene Day,

Faculty of Nursing, University of Alberta

Phone: 1-780-492 4742 Email: kate.caelli@ualberta.ca

Phone: 1-780-492 6785 Email: rene.day@ualberta.ca

Please circle either "yes" or "no":

Do you understand that you have been asked to be in a research study?	Yes	No
Have you read and received a copy of the attached Information Letter?	Yes	No
Do you understand the benefits and risks involved in taking part in this research study?	Yes	No
Have you had an opportunity to ask questions and discuss this study?	Yes	No
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason and it will not affect your care.	Yes	No

Has the issue of confidentiality been explained to you?	Yes	No
Do you understand what the data collected in this study will be used for?	Yes	No
Do you understand that the data you provide for this study may be analyzed in future studies?	Yes	No
Do you agree to the use of the data for the purposes described?	Yes	No

This study was explained to me by: ________________________ Date: _____________

I agree to take part in this study.

_________________________ _______________________

Signature of Research Participant/Date Witness (if available)

______________________________ ______________________________

Printed Name Printed Name

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

________________________________ ______________________________

Signature of Investigator Date

IF YOU WISH TO RECEIVE A SUMMARY OF THIS STUDY WHEN IT IS COMPLETED, PLEASE COMLETE THE FOLLOWING:

NAME:____

____

ADDRESS:____

___

EMAIL ADDRESS: ____

Appendix D

CONFIDENTIALITY AGREEMENT

Title: Changing a dressing: the nurse's experience.

Investigator: Rosemary Kohr, RN, PhD Candidate

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I agree to protect the individual's right of privacy and confidentiality by not disclosing the name or any other pertinent characteristic which could lead to the identification of the study participants.

______________________	______________________
Signature	Title
______________________	______________________
Printed Name	Date
______________________	______________________
Signature of Investigator	Date

Appendix E

Demographic Data of Participants

To help me with my research, I would like to have some additional information about you and your background. If there are questions that you do not feel comfortable answering, just leave them blank. This information will be included in the final research findings, but it will be done so that you cannot be identified.

What year were you born? ____________

How many years have you been a nurse? _________________

For how many years have you provided wound care?_____________

What is the highest level of education you have obtained in nursing?

__________ Diploma in nursing

__________ Baccalaureate in nursing

__________ Masters in nursing

__________ PhD in nursing

Do you have an educational background that is not in nursing? _____________

If so, what is it? ____________________________________

Have you taken any wound care courses? _____

If yes, please list: __________________________

—

What is your current working status? (Please give in hours/week)

_______ Full-time

_______ Part-time

_______ Casual

In which setting do you work:

_______Acute care (hospital)

_______Long term care

_______Community care

Thank you!